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BOLETIN

DE LA

ASOCIACION MEDICA DE PUERTO RICO

ORGANO OFICIAL

PUBLICACION MENSUAL

Ave. Fernández Juncos, Parada 19. Santurce, Puerto Rico.

Entered as second class matter, January 21, 1931 at the Post Office at San Juan, Puerto Rico, under the act of August 24, 1912.

SUMARIO

SUSCRIPCION ANUAL: TRES DOLARES

BOLETIN DE LA ASOCIACION MEDICA DE PUERTO RICO

(Publicación Oficial de la Asociación Médica de Puerto Rico)

Avenida Fernández Juncos, Parada 19
Santurce, Puerto Rico

El BOLETIN DE LA ASOCIACION MEDICA DE PUERTO RICO es el órgano oficial de la Asociación Médica de Puerto Rico. Se publica el día último de cada mes, constando cada volumen de 12 ediciones.

Los trabajos originales deben ser enviados al Editor-en-Jefe, Apartado de Correos 3866, Santurce 29, Puerto Rico, o entregarse directamente en la Secretaría de la Asociación Médica, Avenida Fernández Juncos, Parada 19, Santurce, Puerto Rico.

Los originales deben venir escritos a máquina, a doble espacio.

Las citas bibliográficas deberán mencionar, en el siguiente orden de sucesión: apellido del autor; iniciales de sus nombres; título del trabajo; título del periódico (abreviado); año; volumen y página. Las citas llevarán un número de acuerdo a su orden de presentación en el texto y correspondiente a la numeración colocada al final.

Si el artículo viene acompañado de ilustraciones, debe indicarse en el texto el sitio donde se desea que sean éstas intercaladas. Al dorso de cada ilustración debe hacerse constar claramente el título que deberá acompañarla.

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Tres Dólares
Suscripción Anual

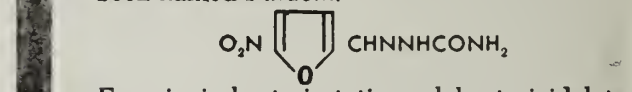
Entered as second class matter, January 21, 1931 at the Post Office at San Juan, Puerto Rico under the act of August 24, 1912.

P. O. Box 3081 — San Juan, P. R.

Announcing

a New Chemotherapeutic Agent

The nitrofurans, a new class of antibacterials, are a recent discovery of Eaton Laboratories[1]. One, especially, is highly effective. This has been named *Furacin.*



Furacin is bacteriostatic and bactericidal to many *gram-positive* and *gram-negative* bacteria, and remains effective in the presence of body fluids. It is stable and low in toxicity.

First Available in FURACIN SOLUBLE DRESSING

Dissolved in a bland, water-soluble base, Furacin is first presented in Furacin Soluble Dressing, for topical treatment of wound and surface infections. This preparation liquefies at body temperature and is soluble in blood, pus and serum, which aids penetration to all parts of wounds. It is non-irritating, has a low index of sensitization and does not interfere with healing processes.

The outstanding results of clinical trials in both military[2] and civilian[3] practice indicate that it possesses important advantages in comparison with sulfonamides and penicillin used topically.

Indications:

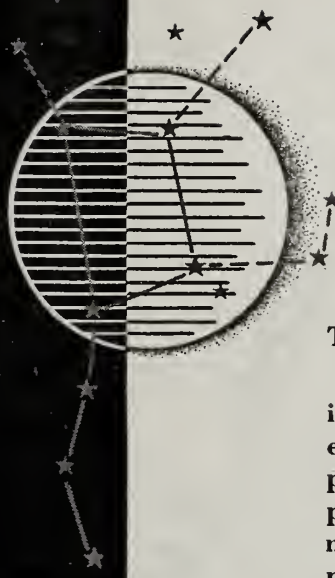
Infected surface wounds, or for the prevention of such infection—infections of third and fourth degree burns—carbuncles and abscesses after surgical intervention—infected varicose ulcers—superficial ulcers of diabetics—secondary infections of eczemas—impetigo of infants and adults—treatment of graft sites preparatory to skin grafting, and later, to prevent infection—osteomyelitis associated with compound fractures—secondary infections of dermatophytoses.

EATON LABORATORIES Inc.
NORWICH, NEW YORK

1. Dodd, M. C. and Stillman, W. B., J. Pharmacol. & Exper. Therap. *82*:11, 1944.
2. Snyder, M. L., Kiehn, C. L. Christopherson, J. W., Military Surgeon *97*:380, 1945.
3. To be published.

For literature on Furacin Soluble Dressing, write *The Medical Director, Eaton Laboratories, Inc., Norwich, N. Y.*

Distribuidor: CESAR CASTILLO, Tetuán 10, San Juan, P. R.



clearly defined

THE MALE CLIMACTERIC SYNDROME

is now recognized as a clearly defined entity, and may be suspected to be present when middle-aged men in the prime of life complain of tiredness, nervousness, insomnia, vague pains and impotence.

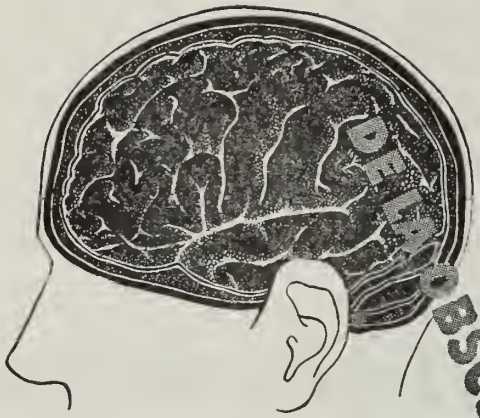
ORETON

Therapy with *Oreton*, testosterone propionate, frequently alleviates these manifestations, if they are due to insufficient hormone, and restores male climacteric patients to former physical and mental vigor.

SCHERING

Schering CORPORATION • BLOOMFIELD, N. J.

Distribuidor: CESAR CASTILLO
Tetuán 10, San Juan, P. R.



Más de 1000 artículos publicados durante los últimos años en las más importantes revistas médicas del mundo, acreditan el SULFATO de BENZEDRINA como un agente de positivo valor terapéutico en el tratamiento coadyuvante, no solamente de los estados mentales depresivos, sino también como un poderoso auxiliar en la terapia del alcoholismo crónico y de la obesidad.

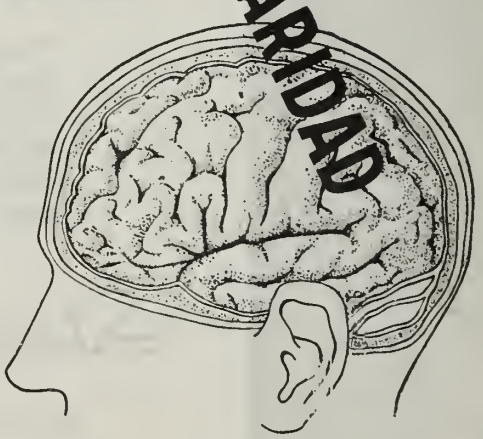
A su petición le enviaremos directamente literatura, posología y muestras sobre este producto.

EN la terapia coadyuvante de los estados de depresión mental simple, tan frecuentemente acompañados con la "fatiga crónica" (tan bien descrita por el famoso Dr. Alvarez de la Clínica de los hermanos Mayo), la profesión médica tiene en el Sulfato de Benzedrina un estimulante eficaz del sistema nervioso central, capaz de producir todos, o algunos de los siguientes efectos:

I. Aumentar la actividad mental, el interés y la accesibilidad.

II. Aumentar los sentimientos de autoseguridad, autobienestar y optimismo.

III. Estimular la acción psico motora; aumentando la capacidad para el esfuerzo físico y mental.



TABLETAS DE SULFATO DE BENZEDRINA

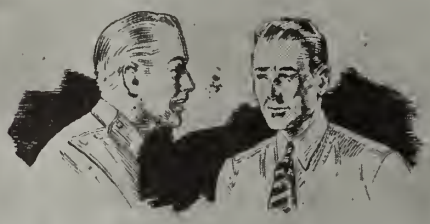
SKF 1841 1944

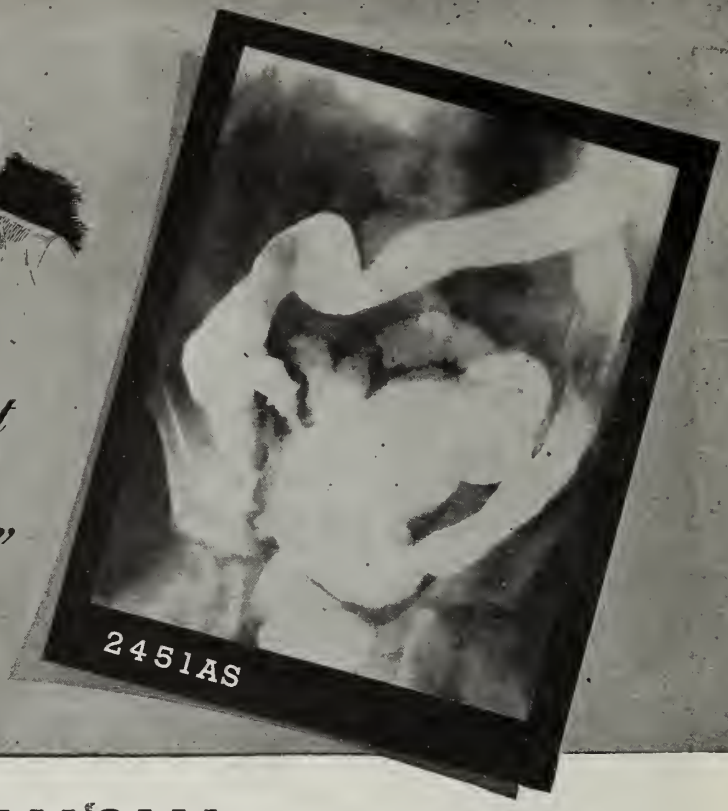
LABORATORIOS SMITH, KLINE & FRENCH
FILADELFIA, PA., E. U. A.

MAS DE 100 AÑOS SIRVIENDO A LA PROFESION MEDICA

Wyeth

REG. U. S. PAT. OFF.





"First we must stop that Diarrhea!"

KAOMAGMA KAOLIN IN ALUMINA GEL

. . . for quick relief from diarrhea

There are many diseases of the gastrointestinal tract in which diarrhea is a symptom. Before specific treatment is begun, however, the physician frequently finds it necessary to check the diarrhea quickly in order to prevent the loss of body salts and water. For this purpose, KAOMAGMA acts promptly and safely.

KAOMAGMA consolidates fluid stools.

KAOMAGMA coats and protects irritated mucosa.

FOR DIARRHEA CONTROL administer two tablespoonfuls of Kaomagma Plain, in a little water, at the onset. Follow with one tablespoonful after each bowel movement.

Supplied in 12-Fluidounce Bottles

KAOMAGMA

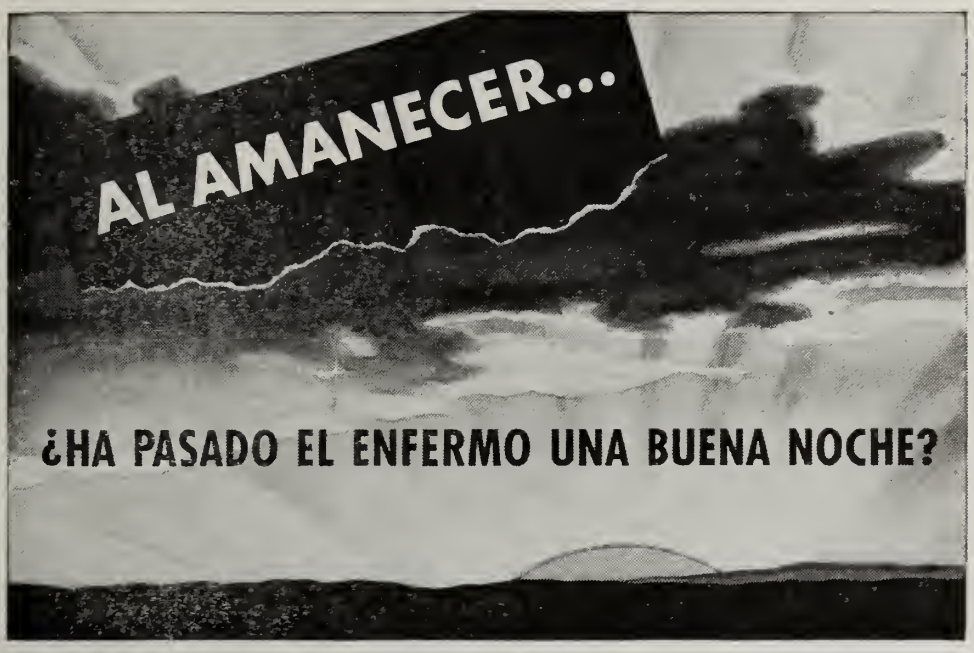
REG. U. S. PAT. OFF.

Kaolin in Alumina Gel

Wyeth

WYETH INTERNATIONAL LIMITED • NEW YORK

Distribuidor para Puerto Rico: FRANCISCO N. CASTAGNET
Tanca 1, San Juan, P. R.



El enfermo, que padece de una inflamación dolorosa, se beneficia grandemente por cualquier medida que se tome para aliviar su molestia, la cual perdure durante toda lo noche.

NUMOTIZINE, aplicado a la hora de acostarse, continúa su efecto analgésico y descongestive por ocho horas o más, y permite que el paciente duerma sin interrupción.

Con NUMOTIZINE no hay necesidad de hacer cambios frecuentes de curación, ni de usar botellas de agua caliente u otros artefactos para producir calor.

NUMOTIZINE

Cataplasma analgésica y descongestiva

INDICACIONES:

Furunculosis

Afecciones del Arbol Respiratorio

Torceduras y Contusiones

Dolores Artríticos

Inflamaciones Glandulares

Tonsilitis

Se suministra en tarros de cristal de 57, 114, 228, 425 y 850 gramos.

NUMOTIZINE, INC.

900 NORTH FRANKLIN ST.
CHICAGO 10, ILLINOIS, E. U. A.

Distribuidor para Puerto Rico: FRANCISCO N. CASTAGNET
Tanca 1, San Juan, P. R.

En el renglón de bolsas de goma hay dos tipos "SR" que se destacan netamente por sus sobresalientes cualidades. Ambas son bolsas de *"doble uso"*: para hielo o agua caliente.

La bolsa TWIN-BAG, de boca ancha y reforzada en su base—su material es extra resistente—tapa sujeta con una cadena—viene provista de hiladillas para sujetarla al cuerpo.

La bolsa STOPPERLESS, cuyo cuello enterizo no permite filtraciones. La abertura grande facilita llenarla con cubitos de hielo. Al usarla a la inversa, no hay peligro de quemarse con el vapor de agua.

FABRICANTES DE LOS GUANTES "SR" STANDARD PARA CIRUJANOS

The **SEAMLESS** **SR** **RUBBER** *Company*

NEW HAVEN, CONNECTICUT
E. U. A.

Marca de Fábrica Registrada

FABRICANDO ARTICULOS DE GOMA DESDE 1877

Agentes: PELEGRINA & LLORENS, Inc.
Salvador Brau 70 — San Juan 17, P. R.

Tratamiento fisiológico de...

AMIBIASIS, COLITIS, DISENTERIA y ciertos ESTADOS DIARREICOS

por el cambio de la FLORA INTESTINAL al beneficioso LACTOBACILO ACIDOFILO

TRILACTIC

con LACTOSA, CALCIO y FOSFORO

Muchos trastornos colónicos están asociados con ausencia o deficiencia de L. acidófilo, por lo cual TRILACTIC contribuye a devolver la normalidad en el estado intestinal al acelerar la formación de flora acidófila en grado predominante.

TRILACTIC * es una forma polimolecular de ácido láctico, que se disuelve con lentitud, especialmente preparada para crear un pH en el colon que sea favorable al desarrollo de flora acidófila. La fórmula de TRILACTIC incluye lactosa—carbohidrato nutritivo ideal para el L. acidófilo... y calcio y fósforo que son esenciales para el desarrollo normal de flora acidófila.

Por tanto, la acción de TRILACTIC es combatir la bacteria hostil y la infección y promover el desarrollo del beneficioso L. acidófilo.

Sencillo, seguro, en armonía con la fisiología normal. De valor por sí solo combinado con otra terapia específica..

AJUSTADO A LA ETICA MEDICA
Y USADO POR LA PROFESION
MEDICA DESDE 1938

En forma de polvo...
fácil de administrar

Literatura y muestras, a solicitud de los señores médicos.

* Marca Registrada Of. Pat. de E.U.A.

PROFESSIONAL LABORATORIES INC.
21 Hudson Street New York 13, N. Y.

Distribuidores Exclusivos para Puerto Rico

PELEGRINA Y LLORENS, INC.

P. O. Box 3631, San Juan, P. R.

El Oftalmoscopio Binocular de Bausch & Lomb

SI BIEN el oftalmoscopio de mano presta buen servicio en amplio campo de uso, el examen verdaderamente exacto y riguroso de la retina para descubrir el estado patológico, exige la percepción estereoscópica que proporcionan la profundidad y gran aumento. Para llenar este requisito se ha introducido el Oftalmoscopio Binocular de Bausch & Lomb. Su campo de vista es amplio, se puede controlar el tamaño de la imagen y variar la iluminación libre de rojo. Su manejo es fácil. Es sorprendente la calidad de la imagen que se obtiene con este binocular.

Agente: H. V. GROSCH CO.
Comercio St. 21 - San Juan

BAUSCH & LOMB
Optical Co. - Rochester, N. Y., E.U.A.
Fundada en 1853

Porqué los bebés asimilan KLIM fácilmente

Miles de médicos recomiendan la leche Klim para la alimentación infantil porque es *leche íntegra* de mayor digestibilidad.

Esto significa que el bebé asimilará rápidamente todos los elementos nutritivos obtenibles de la leche, el alimento más importante en la dieta humana.

La leche Klim es más asimilable para el delicado sistema digestivo del bebé, porque durante el procedimiento de pulverización *se suavizan los coágulos* y se *reducen considerablemente las partículas de grasa.*

ENVASADA ESPECIALMENTE

Klim es envasada en latas al vacío. Ni siquiera el aire puede penetrar y alterar su pureza. Y *Klim contiene* las vitaminas y minerales, grasas y proteína esenciales para una dieta perfectamente equilibrada.

¡Puede usted recomendar la leche Klim sin reserva!

KLIM

LA PREFERIDA EN TODO EL MUNDO

Para informes profesionales y tablas de alimentación acerca de Klim escriba a:
THE BORDEN COMPANY, 350 MADISON AVENUE, NEW YORK 17, N. Y., U. S. A.

Distribuidores para Puerto Rico:
PLAZA PROVISION COMPANY, Allen 15, San Juan P. R.

Even at dilutions as high as

1:20

Lorophyn Jelly kills all spermatozoa in less than one minute!

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

Lorophyn jelly

Lorophyn Jelly embodies four outstanding advantages:

1. Rapid spermicidal effect, even in high dilutions;*
2. Excellent spreading and sperm-contact properties;
3. Effective properties as a physical barrier;
4. Proved non-toxicity and absence of irritation.

*In tests by the modified Brown-Gamble method.

Active Ingredients. Phenylmercuric Acetate 0.05%, Polyethylene glycol of mono iso octyl phenyl ether 0.3%, Methyl p-Hydroxy Benzoate 0.05%, Sodium Borate 3.0%.

Use the coupon for further data.

EATON LABORATORIES Inc.
NORWICH, NEW YORK

MEDICAL DIRECTOR
Eaton Laboratories, Inc., Norwich, N. Y.

Please send me further scientific data, & professional literature on Lorophyn Jelly.

NAME_____

SPECIALTY_____

ADDRESS_____

CITY_____ STATE_____

Distribuidor: CESAR CASTILLO, Tetuán 10, San Juan, P. R.

in pregnancy

FOR THE MANAGEMENT OF CONSTIPATION

Increased pressure due to the growing fetus, lack of exercise and altered diet are factors which may induce constipation during pregnancy.

In such instances Cascara Petrogalar, in small, regulated doses, will help the patient to have safe, comfortable bowel movement without danger of hyperemia of the pelvic region.

Petrogalar permeates the intestinal content, providing unabsorbable moisture to the feces, which results in a soft, easily passed stool and early restoration of "habit time." Contains nonbitter fluidextract cascara sagrada 13.2%. Mineral oil 65%.

SUPPLIED IN PINT BOTTLES

CASCARA

Petrogalar

REG. U. S. PAT. OFF.

Wyeth

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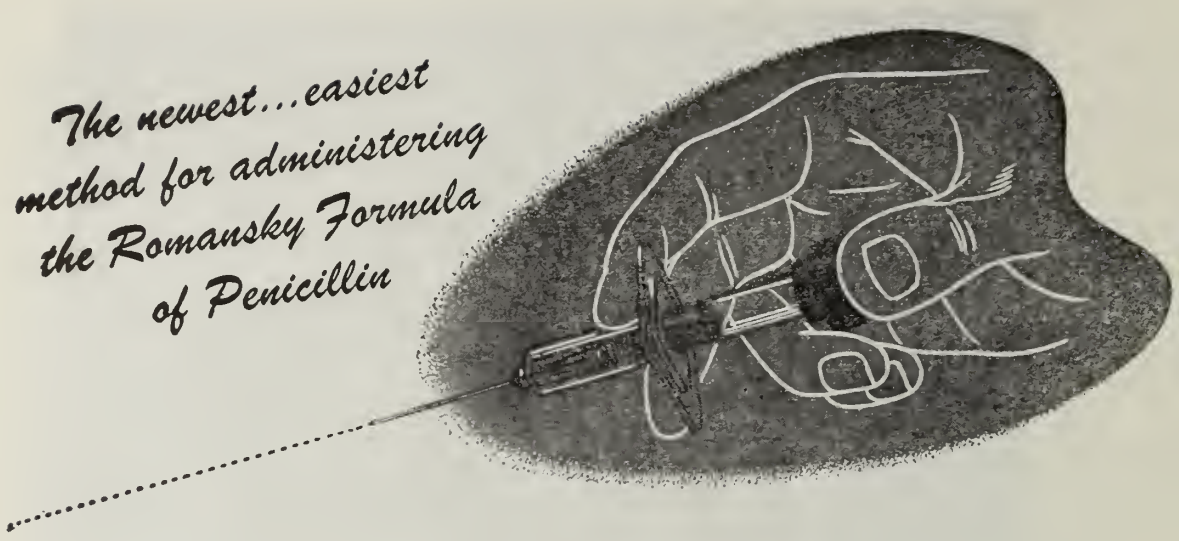
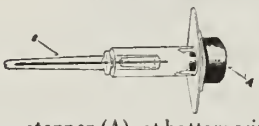
The newest...easiest method for administering the Romansky Formula of Penicillin



Now the physician needs merely to slip a new Abbott penicillin cartridge into a syringe and start the injection. This convenient, sterile unit, always ready for immediate use, consists of: (1) a cartridge containing a single 1-cc. dose of 300,000 units of Penicillin Calcium, Abbott, in Oil and Wax (Romansky Formula); (2) a plastic syringe with a fixed, sterile needle. The syringe is designed to be used once and then thrown away; the needle may not be removed or resterilized. The package containing the unit is small and lightweight, and slips easily into the pocket or emergency bag.

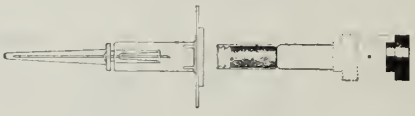
Unit as Removed from Package



Syringe, containing a sterile, 20-gauge needle, is sealed at top with rubber stopper (A), at bottom with removable plastic sheath (B) which protects the sterile needle.

Two-chamber cartridge, supplied with one chamber containing a single 1-cc. dose of 300,000 units of Penicillin Calcium, Abbott, in Oil and Wax (Romansky Formula), the second chamber empty.

Unit Ready for Assembly

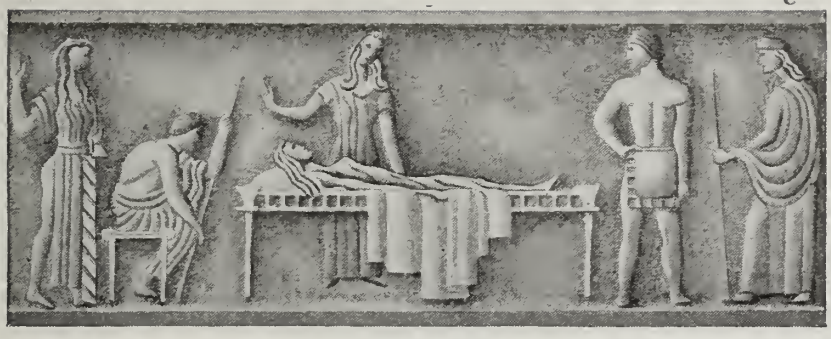


To assemble the unit for use, the rubber stopper is removed from the syringe and attached to the open end of the cartridge to form a plunger. To make the injection it is necessary only to insert the cartridge-plunger into the syringe until upper end of the needle punctures the rubber diaphragm.

Other New Abbott Penicillin Specialties

- **PENICILLIN OINTMENT** *ABBOCILLIN*
  1000 units Penicillin Calcium per Gram (*in 1-ounce tubes*)
- **PENICILLIN OPHTHALMIC OINTMENT** *ABBOCILLIN*
  1000 units Penicillin Calcium per Gram (*in ⅛-ounce tubes*)
- **PENICILLIN TROCHES** *ABBOCILLIN*
  Each Trache contains 1000 units (*in bottles of 24*)
- **PENICILLIN TABLETS** *ABBOCILLIN*
  Each tablet contains 25,000 units (*in bottles of 12 and 25*)

Abbott Laboratories P. R.
80-82 S. Brau St. - P. O. Box 1082
San Juan, P. R.



*Folvite**

BRAND OF FOLIC ACID (*L. CASEI* FACTOR)

Lederle

The new Synthetic Anti-Anemia Factor

In August of last year, the Research Staffs of Lederle Laboratories, Inc. and American Cyanamid Company jointly issued a statement upon their successful solution of a problem that had previously baffled the best scientific minds—the synthesis of folic acid *(L. casei* factor). Since that time, we have directed the most strenuous efforts toward solving the equally formidable task of producing the substance in substantial amounts. This has proven exceptionally difficult, being analogous to the problem we faced of producing sulfadiazine in 1940.

Success *is* crowning our efforts! Although FOLVITE is now available in limited amounts only, we hope that in the reasonably near future it will be available in somewhat larger quantities.

FOLVITE IS INDICATED FOR

- **Sprue**
- **Macrocytic Anemia of Pregnancy**
- **Gastrointestinal Macrocytic Anemia**
- **Macrocytic Anemia Associated with Pellagra.**

A booklet will be sent upon request.

packages of 25 tablets, 5 mg. each

LEDERLE LABORATORIES, INC.

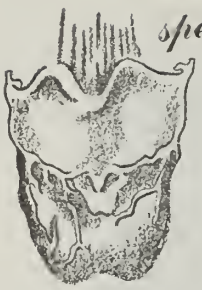
30 Rockefeller Plaza, New York 20, N. Y.

A UNIT OF AMERICAN CYANAMID COMPANY

*Trade-mark

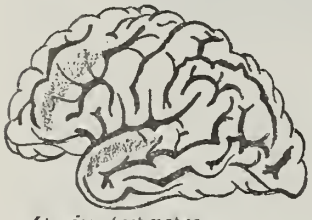
special uses for

BASAL ANESTHESIA



thyroid surgery

Smooth induction of anesthesia without excitement, as obtained by the rectal administration of Avertin with amylene hydrate, is of particular value in the nervous and apprehensive thyrotoxic patient.



brain surgery

Avertin with amylene hydrate tends to lower the intracranial pressure and has been found especially suitable for neurosurgery.

in presence of pulmonary disease

Avertin with amylene hydrate can not cause pulmonary irritation since it is excreted quantitatively by the kidneys. And it decreases the amount of inhalation anesthetic subsequently needed by one-half.

biopsy procedures

Basal anesthesia keeps the patient asleep and ready for radical surgery, while frozen sections, pathologic examinations and consultation are being made.

WRITE FOR DETAILED INFORMATION

Avertin

Trademark Reg. U.S. Pat. Off. & Canada

Brand of TRIBROMETHANOL

WITH AMYLENE HYDRATE

Winthrop Chemical Company, Inc.

Pharmaceuticals of merit for the physician • New York 13, N. Y. • Windsor, Ont

109 M

WINTHROP CHEMICAL COMPANY, INC.

S.M.A. SIMPLIFICA LA ALIMENTACION INFANTIL

FIJESE CON QUE FACILIDAD SE PREPARA:

1 Para cada 30 gramos de leche que se desee, vacíese en la botella a través del embudo, el contenido de un medidor lleno, apretado y raso de polvo S.M.A. Se suministra un medidor con cada lata de S.M.A.

2 Por cada medida de polvo S.M.A. que se use, añádase 30 gramos de agua tibia (*no agua caliente*), que haya sido previamente hervida y enfriada a la temperatura deseada.

3 Colóquese el tapón en la botella y agítese el contenido hasta disolverse.

Si se desea preparar de una vez la fórmula en cantidad suficiente para todo el día, úsese la proporción de una medida de S.M.A. por cada 30 gramos de agua.

S.M.A. se ofrece en latas que contienen 453 gramos cada una.

Producto elaborado por la División S.M.A. de Wyeth Incorporated.

WYETH INTERNATIONAL LIMITED

NEW YORK, N. Y. E. U. A.

WS—1-B

Printed in U.S.A.

EL NIÑO NORMAL

EL NIÑO NORMAL SE DESARROLLA Y CRECE CON S. M. A. IGUAL QUE CON LA LECHE MATERNA

La S.M.A. tiene las siguientes ventajas:

1. Grasa adecuada de fácil digestión asimilación.
2. Proteínas que proporcionan los aminoácidos esenciales necesarios para la nutrición y desarrollo normal.
3. Lactosa (carbohidrato semejante al de la leche materna) en la debida correlación con las proteínas y grasas.
4. Hierro (10 mg. por litro) en cantidad suficiente para prevenir las anemias infantiles.
5. Cantidades uniformes de vitaminas A, B_1 y D (La vitamina C se obtiene del jugo de naranja).

ANALISIS COMPARATIVO DE LA LECHE MATERNA Y LA S.M.A.

Análisis Químico	*Leche Materna*	*S.M.A.*
Grasa	3.59%	3.5–3.6%
Proteínas	1.23–1.5%	1.5%
Carbohidratos (Lactosa)	7.57%	7%
Minerales	0.215–0.226%	0.38%
Hierro	0.00005%	0.0005%
Calorías por onza (30 cc.)	20	20
Calorías por 100 cc.	68	68
Propiedades Físicas	*Leche Materna*	*S.M.A.*
Densidad	1.032	1.032
pH	6.97	6.8–7.0
Depresión del Punto de Congelación	−0.56° C.	−0.56–0.61° C.
Conductividad Eléctrica	0.0023	0.0022–0.0024
Contenido Vitamínico, U.I. por litro		
Vitamina A	6000–7000	7500
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THE TREATMENT OF MURINE TYPHUS WITH PARA-AMINOBENZOIC ACID

A PRELIMINARY REPORT

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The many attempts to find an efficient chemo-therapeutic agent of value for rickettsial infections failed until the discovery by Snyder, Maier, and Anderson[1] that para-aminobenzoid acid when given orally would very effectively reduce the mortality rate of white mice infected with the rickettsia of murine typhus. Furthermore, Hamilton, Plotz and Smadel[2] reported an inhibition of growth of the rickettsia of louse borne typhus and that of murine typhus in the chick embryos treated with para-aminobenzoic acid, thus prolonging the life of the developing embryo. This work was confirmed by Greiff, Pinkerton and Moragues[3] in their studies of the effect of para-aminobenzoic acid in both chick embryos and mice infected with the rickettsia of murine typhus. Anigstein and Bader[4] found that para-aminobenzoic acid was effective in guinea pigs infected with the rickettsia of Rocky Mountain spotted fever. The animals protected by the drug suffered from very few if any signs of the disease, while the controls invariably died from the infection. Hamilton[5] has reported that para-aminobenzoic acid inhibits the growth of this type of rickettsia in chick embryos more efficiently than in the case of typhus rickettsias.

It has been suggested that para-aminobenzoic acid does not act directly on the rickettsias, but that it interferes in some way by modifying unidentified enzyme systems retarding their growth and multiplication within the living tissue cells.[1 2 3] Thus, the drug is not lethal to the organisms, but indirectly stops their development.

The reports on the clinical use of para-aminobenzoic acid are few and spotty. Yeomans et al[6] have used the drug with success in the treatment of humans suffering from louse borne typhus. The reported results indicate that the drug modifies the course of the disease by shortening its duration and that it decreases the severity of the symptoms. The authors[9] reported no toxic reactions in spite of heavy doses of as much as 24 to 28 grams in 24 hours, and blood concentrations of 10 to 20 mgs. of the drug per

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100 cc. More recently, Rose et al[7] have reported a successful trial of the drug in a human case of Rocky Mountain spotted fever. The drug exercised beneficial effects on the disease by shortening its course.

In view of the scarcity of reports in the literature on the use of para-aminobenzoic acid in rickettsial diseases, especially on the effect of the drug in human murine typhus, we consider this preliminary report to be timely. The report is based upon the action of the drug on three orthodox human cases of murine typhus, of which the clinical and laboratory diagnosis is undisputed. All patients were residents of San Juan, P. R., where murine typhus is common, and all were admitted during the month of July, a period of the year when the disease is prevalent in the Island of Puerto Rico.

CASE REPORTS

Case 1. E. M., a 44 year old colored Puerto Rican female was admitted to the medical wards of the San Juan City Hospital on July 6, 1946, in a stuporous condition.

It was stated that she was feeling well until the morning of July 3, 1946, when she suddenly developed marked general malaise. Very soon afterwards she felt somewhat chilly and developed a high fever accompanied by intense frontal headache, pain in the eyes and photophobia, and severe pain over the lumbar region. In the mid-afternoon of the day of onset, she began to fall into a state of stupor that increased in intensity during that night, and which forced her family to seek her hospitalization. Her past and family histories were non-contributory.

Physical examination revealed a middle-aged colored woman in stupor, but responsive to various stimuli. The oral temperature was 104º F., the pulse 120 per minute, the respiration 36 per minute, and the blood pressure 114 mm. Hg. systolic and 60 diastolic. The conjunctivae were markedly congested, and the tongue moderately coated. Pressure over the eyeballs elicited some pain. The lungs were clear to percussion and auscultation, and the heart was normal except for tachycardia. The abdominal, as well as the rest of the physical exploration was negative.

On admission she had a red cell count of 3,200,000 with a hemoglobin of 71 per cent. The white cell count was 7,900 per cu. mm. of blood, with a differential of 71 per cent neutrophiles and 29 per cent lymphocytes. Repeated blood smears for malaria were reported negative. Urinalysis demonstrated slight traces of albumin and a few white blood cells per high power field, but was otherwise negative. The blood study for syphilis, as well as the stool examinations for ova of parasites were found negative.

In spite of the negative blood smears for malaria, the patient was given one gram of quinine intramuscularly but further observation failed to produce any improvement. She was given 1,000 cc of 5% glucose in normal saline solutions intravenously, and on coming out of her stuporous condition she complained severely of cephalalgia, photophobia, and pain over lumbar region.

On July 8, 1946, five days after the onset of her illness the serum agglutinations for Proteus OX 19 were reported positive in dilutions of 1:50, and on July 14, 1946, (11 days after onset), the agglutinations were reported positive in dilutions of 1:200.

On July 9, 1946 (six days after onset) a typical rash appeared in the thorax, and the generalized muscular pains, cephalalgia, and photophobia required strong sedation.

At 4:00 P. M. on July 10, 1946 (seven days after onset) 4 grams of para-aminobenzoic acid in 50 cc. of chilled 5 per cent sodium bicarbonate solution flavored with lemon juice were given orally. This initial dose was followed by 2 grams doses of the drug in 25 cc. of the same vehicle every 2 hours as tolerated.

On July 11, 1946, after the administration of 18 grams of the drug, the headache and general body aches had disappeared but the temperature remained elevated. The drug was continued, and on July 12, 1946, (9 days after onset) after an intense diaphoresis the temperature dropped from 130º F. to normal in less than 24 hours. The total amount of the drug administered up to that time was 50 grams, and it was continued until July 15, 1946 after the patient had been afebrile and asymptomatic for four days, and after a total administration of 98 grams. Further stay in the hospital demonstrated no tendency to recurrence. On July 18, 1946, a white cell count showed a total of 7,450 with a differential of 48 neutrophiles and 52 lymphocytes. No toxic reactions from para-aminobenzoic acid were recorded. Her convalescence was smooth. She developed a voracious appetite and gained some weight, and was discharged after 16 days of hospitalization.

Case 2. M. T., a 22 year-old white Puerto Rican male was admitted to the San Juan City Hospital on July 13, 1946 complaining of headache, chills, fever, pain in the calves,

anorexia, weakness and photophobia of eight days duration. The past and family history were irrelevant.

The patient was well until July 6, 1946, when he experienced a severe frontal headache soon followed by a high fever preceded by a shaking chill, weakness, and pains in the calves. Photophobia made its appearance on the second day of illness, as well as generalized body aches and pains. The patient was forced, to go to bed, and received no medical attention, but tried some "home remedies." The symptoms intensified after the fourth day of illness, and the patient sought admission to the hospital on the eighth day of illness.

On physical examination he was found to be acutely ill, but well oriented, and could give a rational account of his illness. His oral temperature was 102° F., pulse 104 per minute, respirations 24 per minute, and the blood pressure 90 mm. Hg. systolic and 58 diastolic. There was a mottled erythematous rash throughout the body, and a marked bulbar and palpebral conjunctival infection. The tongue was thickly coated. The tip of the spleen was barely palpable on deep inspiration. The rest of the physical examination was essentially negative.

On admission he had a red cell count of 3,620,000 with 78 per cent hemoglobin, a white cell count of 6,300 per cu. mm. of blood with a differential count of 62 per cent neutrophiles and 38 per cent lymphocytes. A blood smear for malaria, urinalysis, and a stool examination for ova of parasites were all negative. Serum agglutinations for Proteus OX 19 were reported positive in dilutions of 1:400 on his third day, and ten days after onset of the illness. Agglutinations done on his fifth hospital day, and on his 13th day of illness were reported positive in dilutions of 1:1,600.

Treatment with para-aminobenzoic acid was started immediately after admission. The first dose was 4 grams, and was continued in doses of 2 grams, every four hours diluted in a chilled 5% solution of sodium bicarbonate and flavored with lemon juice. After receiving 18 grams of the drug, the patient was subjectively improved. The cephalalgia was not as severe, and the general body aches and pains were much alleviated, and these symptoms had disappeared completely by the third day of treatment, when the temperature started to fall, and dropped to normal on the fourth day of treatment after a great deal of diaphoresis. His convalescence started on the eleventh day of the disease, and after he had received 62 gram of para-aminobenzoic acid. The drug was continued for two more days, and then omitted after receiving a total of 86 grams. The convalescence has been quite smooth up to the time of this report. No toxic reactions from the drug were noticed.

Case 3. R. F., a 19 year old white Puerto Rican male was admitted to the San Juan City Hospital on July 11, 1946 tsating that he was feeling in perfect health until July 5, 1946 when he was suddenly taken with a severe, throbbing, frontal headache which was soon followed by a severe shaking chill and a high fever, accompanied by muscular aches and pains all over the body. The condition increased in severity after he experienced chill on the two days following the onset of his illness. The patient was seen by a private physician who prescribed atabrine in proper doses in spite of a negative smear for malaria, but this medication was to no avail. The patient sought admission to the hospital on his fifth day of illness.

On physical examination he was found to be a well developed and well nourished young male of 19, who appeared acutely ill, but responsive to questioning. His oral temperature was 100.5° F, the pulse 106 per minute, and the blood pressure 110 mm. Hg. systolic and 70 diastolic. There was a diffuse erythematous rash throughout the body except in the lower extremities, and marked bulbar and palpebral conjunctivitis. The tongue was coated with yellowish-brown material. The lungs revealed a few inspiratory sibilant rales bilaterally. The rest of the examination was negative.

The red cell count on admission was 3,440,000 with 76 per cent hemoglobin; the white cell count 7,450 with a differential count of 58 neutrophils and 42 per cent lymphocytes and the urinalysis, blood serology, and repeated blood smears for malaria were negative. Serum agglutinations for Proteus OX 19 on the second hospital day (6 days after onset) were positive in dilutions of 1:100, and when repeated on his fifth hospital day (9th day of illness) were reported positive in dilutions of 1:12,800.

Tratment with para-aminobenzoic acid was started on admission with an initial dose of 4 grams in 50cc of chilled 5% sodium bicarbonate solution with lemon juice, and subsequent doses of 2 grams in 25cc of the same vehicle every two hours. There was a marked subjective improvement after the second day of treatment in spite of the high temperature, but the headache and the general body aches and pains had disappeared. The rash had turned dusky brown in color. The anorexia and some constipation were the only complaints on the fourth hospital day. The temperature started to fall by lysis on July 13, 1946 (8th day of illness and 3rd day of hospitalization), and reached normal levels two days later after receiving 104 grams of the drug. The drug was omitted two days later after a total of 136 grams were given, and after recovery was evident as judged from the general wellbeing of the patient. Convalescence has been smooth up

to the present time. There were no toxic reactions.

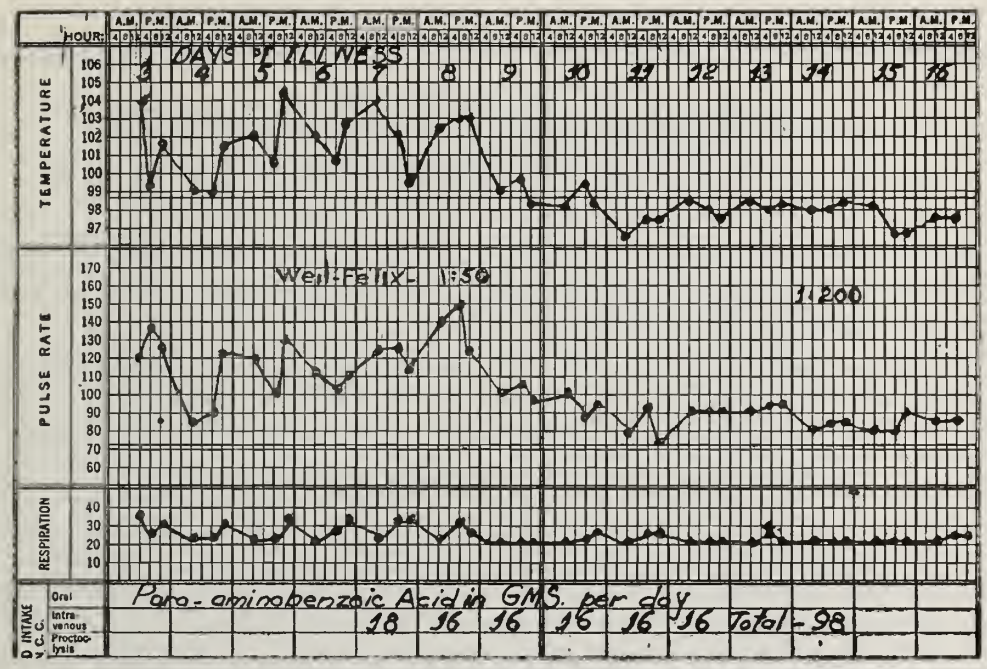
COMMENT.

Although the mortality rate of murine typhus is quite low, (calculated as 1 per cent or less) fatalities occurring almost exclusively among the very weak or among the aged who could be very easily victims of other infections, its importance can not be denied not because of its mortality, but because of its morbidity. Its course is limited to 14-16 days of high fever, severe cephalalgia and pains in the muscles, constipation, and in some instances, a bothersome dry cough. A patient suffering from murine typhus fever is condemned to suffer from these severe symptoms for the natural duration of the disease if treated symptomatically, since this method of therapeusis does not actually help very much in the alleviation of his suffering. Some patients suffering from this illness present symptoms which because of their magnitude, are certainly out of proportion with a favorable outcome. Furthermore, the defervescence of this acute illness is followed in many cases by a relatively long convalescence characterized by weakness, pain in the muscles, and marked indolence. By shortening the course of the disease, or aborting the infection the patients may perhaps be saved from a long suffering and from a prolonged period of convalescence.

Furthermore, the great majority of the sufferers from murine typhus seek hospitalization and the disease strains the pockets of those belonging to the middle class, and the hospital care for the indigent imposes demands on the tax payers. In addition, the average hospital stay for a typhus patient receiving supportive therapy is longer, than in those in which specific therapy is instituted, if this therapeusis were successful. In this way hospital occupancy could be shortened, and better service could be given by both public and private institutions, in this era of limited hospital facilities, especially for the indigent.

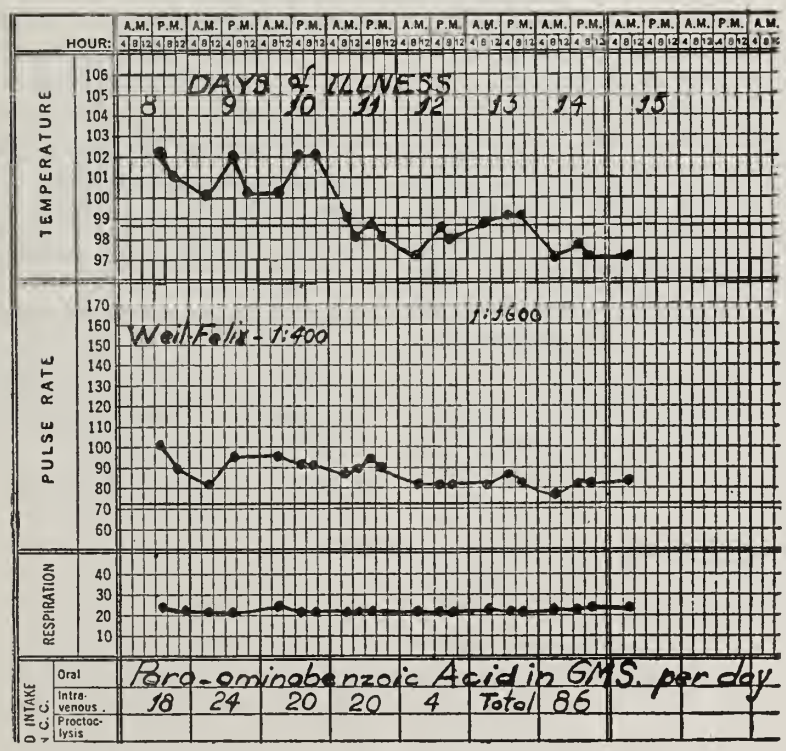
We are reporting herein the results obtained from the use of para-aminobenzoic acid in murine typhus. In spite of the limited number of cases certain observations deserve consideration.

All the patients were suffering from symptoms typical of murine typhus, and in every instance positive serum agglutinations, of Proteus OX 19 were obtained in increasing titers as the disease progressed. This makes the diagnosis of murine typhus unquestionable. All the patients received para-aminobenzoic acid in relatively heavy doses, showing definite subjective improvement within the first 24 to 48 hours after instituting the treatment. The cephalalgia and the general body aches and pains disappeared within this time in spite of no definite changes in the fever curve. The temperature started to fall between the first 48 to 72 hours of treatment, and had reached normal levels on the third or fourth day. In two instances (cases 1 and 2) fever fell by crisis after a marked diaphoresis, and in one (case 3) it fell by rapid lysis. Case I was admitted on his third day of illness, para-aminobenzoic acid was given on the seventh day after onset, and she was afebrile and asymptomatic by the ninth day. In case 2 the patient was admitted on his eigth day of illness, the drug was administered on the same day, and was afebrile and asymptomatic by the eleventh day. Case 3 was admitted on his fifth day of illness, was started on the drug on the same day, and by the ninth day he was asymptomatic but not totally afebrile until the tenth day. (See charts 1, 2, 3). No toxic symptoms were reported, in spite of doses ranging between 16 and 24 grams daily.



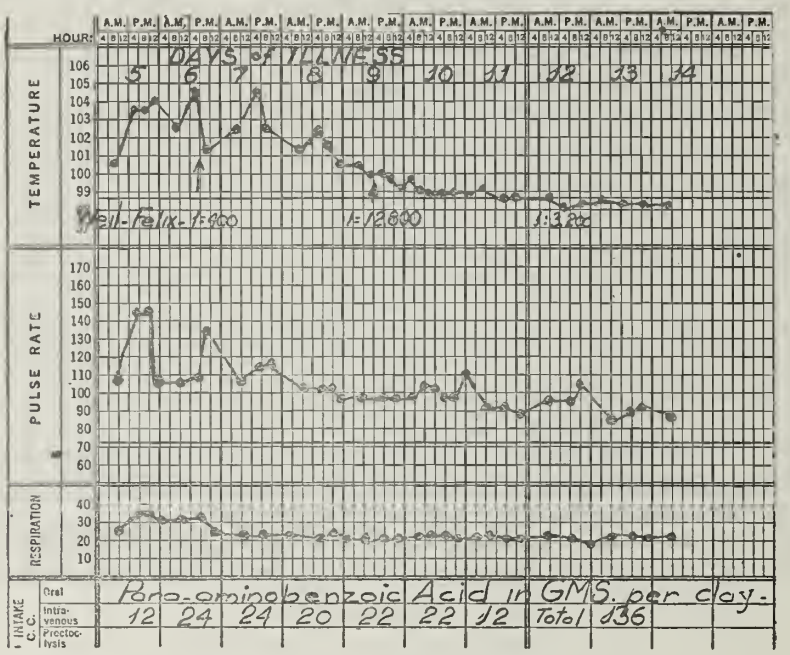
CASE I. *MURINE TYPHUS.*

Note: Temperature Curve after treatment.



CASE II. *MURINE TYPHUS.*

Note: Temperature Curve after treatment.



CASE III. *MURINE TYPHUS*

Note: Temperature Curve after treatment.

SUMMARY AND CONCLUSIONS

Three patients suffering from murine typhus were treated with para-aminobenzoic acid. The drug excercised some beneficial effects in ameliorating the symptoms within the first 24 to 48 hours. The fever fell by crisis in two instances, and in one by lysis. All patients were asymptomatic and afebrile within three or four days after the treatment was instituted, and the course of the disease was radically shortened. No toxic symptoms or signs were observed.

Editors Note: The present edition of the BOLETIN is being published by the end of July and for this reason this study which was made during the mon h of July is appearing in the June's edition.

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DUODENAL STASIS

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A REVIEW OF THE FACTS PERTAINING TO ALTERATIONS IN DUODENAL TRANSIT.

Impaired peristalsis of the duodenum, because of its frequency, creates almost as numerous complaints as ulcers, cancer, chronic gastritis, or biliary lithiasis. Whether disturbances of the duodenal transit are the reason for many of these conditions is still a point for discussion between clinicians, physiologists, and radiologists.

Mechanical and congenital stenosis of the duodenum were mentioned as early as 1733 by Calder, a physician of Edinburgh. In the middle of the Eighteenth Century, several physicians reported compression of the duodenum by the pancreas and other organs. Mechanical stenosis, caused by pressure of the superior mesenteric artery and the pedicle of the mesentery, have often been reported by French and Canadian physicians and radiologists. More recent reports have come from autopsies.

Mechanical causes of stenosis are congenital sharp curves of the duodenum, bands of congenital adhesions, anomalies of position, abnormal laxity, or mobility of the peritoneum. The lesions that can bring about mechanical stenosis of the duodenum are either intrinsic, such as inflammation, diverticulae, and foreign bodies (gall stones), or extrinsic, as tumors of the stomach, of the liver, the biliary ducts, the pancreas, the kidneys, and of the peritoneum. Adenopathies, either an inflammatory band of adhesions or an enlarged, distended gall-bladder, ptosed kidneys, aneurism of the aorta, and compression of the superior mesenteric artery, may also produce mechanical stenosis.

Duodenal stasis is intermittent most of the time, which would rule out the majority of mechanical causes, mentioned above. This was demonstrated by radiologists Case, Friedenwald and Feldman in 1933, who observed that the condition disappears and reappears in the course of an examination. A genu-pectoral position does not often end the trouble, which would occur if compression by the superior mesenteric artery were the cause. It is a fact, however, that relief from duodenal stasis is more often obtained by medical means (wearing a belt) than by surgery.

When mechanical stenosis is eliminated as the cause of duodenal stasis, there still remains for consideration, and possible treatment, the fact that the disturbance may be of a nervous origin. In some instances, duodenal stasis has to be considered as a neuro-muscular condition, whether idiopathic or as a consequence of a nearby lesion, such as an ulcer, lithiasis, gastric cancer, appendicitis, colitis, periovary inflammation, perivisceritis, and so forth. It may also be due to the presence of parasites, as in ankylostomiasis, giardiasis, and so forth.

We know that duodenal dilatations, due to distant lesions— cancer of the lesser curvature of the stomach, ulcer of the duodenal bulb, cholecystitis— are caused by inhibition of the vagus nerve. Just as the eosophagus is dilated by a cardiospasm, or the stomach is dilated by a pyloric spasm, so is the duodenum dilated by a spasm that occurs in its lower portion. Literature of the duodenum describes se-

veral muscular rings, usually three to ten centimeters below the ampulla of Vater. It has been said that the digestive tract is divided not only into several anatomical sections, separated by macroscopic sphincters, such as the ostium of the eosophagus, the cardia, the pylorus, the ileo-cecal valve, and the anus, but also into physiological sections, separated by purely functional sphincters which, in ordinary circumstances, do not appear to be innervated by the vagus or the sympathic nerves. However, when an abnormal excitation occurs in one of these nervous systems, the sphincters show some muscular contraction, thus producing a prolonged stenosis in a short section, with dilatation of the intermediary segments.

The Treitz muscle, suspensory of the duodenum, is made up of striated fibers in its upper portion and of smooth fibers in its lower part. Although atrophied in the adult, it preserves its sympathic innervation that may extend as far as the third section of the duodenum. It is therefore possible that mechanical disturbances are caused in other portions of the small intestine by a sudden distension, or by some other excitation.

Duodenal stenosis and dilatation can also be studied with the help of pharmacodynamics.

As the excitation of the vagus nerve cannot be transmitted in the absence of acetylcholin, so the sympathic nerve cannot act in the absence of sympathin. Under normal conditions, there is an enzyme in the tissues that destroys the acetylcholin by hydrolysis. This enzyme is the lipase cholin. An excess of this lipase prevents cholerginic action of the vagus nerve at a certain point and allows the sympathic nerve to predominate in its functions. Based on these observations, Drs. Jutres and Cantero, of Montreal, have devised a treatment with acetylcholin, which restores vago-sympathic equilibrium. Results appear to confirm their hypothesis.

X-ray examinations are most important in the diagnosis of these duodenal disturbances. Under normal conditions, the passage of food through the duodenum is quite rapid, at the most, thirty seconds. A duodenal transit, which lasts more than this time, may be considered as delayed.

This is what fluoroscopy reveals. A bolus of opaque meal has gone through the pylorus. The bulb is filled and remains dilated during a few seconds when it contracts and empties into the second portion of the duodenum. The food then falls into the lower part of the genu inferius; instead of progressing further, it stays at this point, the genu affecting a saucer-like shape. After a lengthy interval (varying with the gastric activity existant or the manipulations of the radiologist), a new amount of food reaches the pocket and increases its size. The lumen of the duodenum becomes quite enlarged. Thus two facts are established—stoppage in the progress of the bolus and dilatation of the portion of the duodenum where stasis occurs.

When investigating the reason for stoppage of the food, a more or less abrupt change is usually noted in the shape of the opaque column. When obstruction is complete, which is not often, the column is seen as in a vertical plane. In such a case, this shape is caused by pressure from the superior mesenteric artery. Most of the time, however, the end of this opaque column produces an irregular cone-shaped duodenum, with its apex down and slightly turned towards the left. When stasis is not pronounced, varying opacity is observed between the third and fourth segments. While steno-

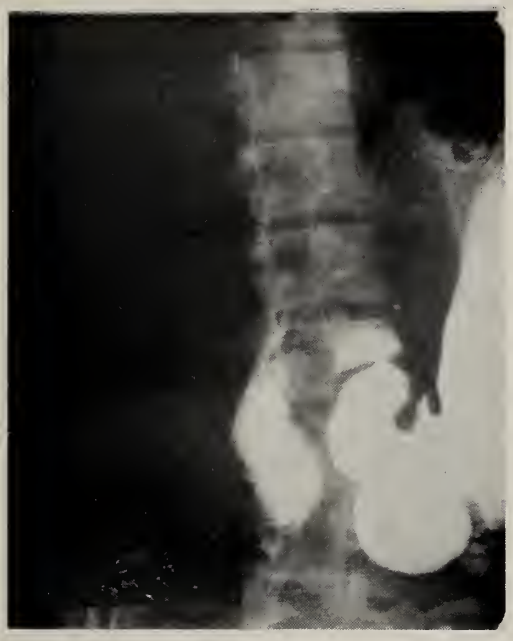

FIG. I
First Degree of stasis. Mild Spasm in D. IV.

FIG. II
D. IV dilated and ptosed; marked spasm at union D. IV and jejunum.

FIG. III
D. III markedly dilated; spasm in D. IV.

FIG. IV
D. III and part of D. IV markedly dilated and ptosed; walls have retained tonus. D. I and D. II are inverted.

FIG. V
Duodenal stasis in case of carcinoma of stomach.

sis is most often observed at a level underneath the superior mesenteric artery, it can also be noted as far as the junction of the duodenum and the jejunum.

Disturbances produced by mobility are always the same. In less pronounced cases, inoperant contractions are observed with the food returning, between contractions, to the genu inferius by force of its own weight. In more pronounced cases, it is a true contra-peristalsis, which alternates with normal peristalsis, shaking, and even twisting the genu inferius, rather strongly. If these motions do not overcome the obstruction, antiperistalsis then pushes the food back towards the bulb, sometimes as far back as the stomach. Certain authors consider this as absolute proof of a pathological condition; others believe it has no pathological significance unless accompanied by gastric symptoms.

Under the fluoroscope, the duodenal spasm is seen to relax once in a while. This is proof that the cause of the phenomenon is not extrinsic but inherent to the duodenum.

When the spasm is light, there seems to be but slight hesitation in the barium passing beyond the junction of the third to the fourth segments, with some antiperistalsis appearing. However, when the spasm is more marked, the genu inferius takes the form of a small atonic pouch similar to that in a distended stomach. In both cases, it is not infrequent to observe gastric retention six hours after ingestion. Evacuation is complete, though, most of the time after the third or fourth hour, yet some barium is always retained in the duodenum.

A third phase, which we refer to as extreme dilatation, is concomitant with pronounced muscular atony. Antiperistalsis is weak and infrequent; the lumen of the duodenum increases not only in its transverse diameter but also in its longitudinal dimension, thus increasing the distance between the genu superius and the genu inferious. The duodenal bulb also participates in this dilatation and acquires a volume two or three times its normal size. In light cases, the folds of the mucosa suffer only slight changes; when these begin to change, they first show hypertrophy: the folds appear to be more numerous and thicker, and they frequently show many clear areas formed by thickened lymphatic follicles. This is the period of hypertonicity of the mucosa, when it endeavors to increase its strength to fight against the obstacle. At the same time, the mucosa gives out antimicrobious secretions.

When the mucosa begins to tire, it loses most of its folis which then become narrow and shallow and appear in the x-rays as a net of thin, clear lines— the so-called "Turtle-back" appearance. Someti-

mes the folds disappear entirely. In the case of extreme atony, peristalsis and anti-peristalisis of the duodenum are extremely weak and sometimes absent. Gastroduodenal stasis is then observed after the sixth hour. This disappearance of the folds of the mucosa may be due to duodenitis, but it is difficult to determine whether stasis is the cause or the consequence of the duodenitis.

Frequently, diverticulae are observed at the union of the third and fourth portions. It has been said that certain duodenal dilatations result from increased pressure on weakened walls produced by aberrant portions of the pancreas, included in these walls.

Whatever the degree of duodenal stasis, palpation under the fluoroscope is usually painful and increase the malaise. Nausea often incites to vomiting.

When duodenal stasis coincides with other lesions, as ulcer of the duodenal bulb, cholecystitis with lithiasis, a chronic appendicitis, and so forth, it becomes secondary, and its cure may be expected after the removal of the organic lesion. If no organic lesion can be found in the abdominal viscera, then duodenal stasis becomes foremost and must be treated accordingly. Gastro-coloptosis coincides frequently with duodenal stasis. However, it is always the latter that has to be treated first.

The frequency of duodenal stasis varies according to the authors and to the meaning given to the word. The condition is usually encountered alone or associated with other abdominal complaints in 90 percent of the patients coming to x-ray examination. The older the patient the more they are exposed to duodenal stasis because of the weakening of all their tissues, particularly, muscular tissue. However, serious duodenal stasis has also been observed in children. The trouble, though, is more often seen in female patients, parhaps due to the fact that the latter come for X-ray examinations more frequently than males and because their neuro-muscular tissue is more easily weakened.

Duodenal stasis is produced by a crisis, and my last from several weeks to several months. The patient loses weight and strength, becomes nervous, pale and jaundiced. During this phase, resistance to infection weakens and becomes serious. For instance, tuberculosis may increase in gravity and bring about death in a few weeks.

Prognosis is not usually serious, however. When the type of life led by the patient brings about the cessation of worries or of overwork, the symptoms of doudenal stasis suddenly cease. The patient eats and sleeps better; he increases in weight; the migraines disappear, and the mental and physical tonus reappear. Should his worries or the excess of work, and so forth, return, then the pathological cycle is renewed. Duodenal stasis is a strong argument for those who speak of "nervous dyspepsia."

Of course, mechanical abstructions can only be relieved by surgery. When compression of the duodenum is due to fibrotic bands of adhesions, to adenopathies, benign tumors, and soforth, the removal of the obstacle brings about a cure. When compression is due to the mesenteric artery, it would seem that a duodenojejunostomy would be in order, though results in this have not been consistently good. If there is a lesion in the duodenum itself, resection of a segment is then necessary.

Functional stasis is treated medically. Drs. Cantero and Jutras have sucessfully used drainage followed by a douche of

the duodenum. If the pylorus is closed, the injection of a small quantity of warm olive oil aids the tube in passing. Drainage is then performed through a syphon effect. When the tube reaches the second portion of the duodenum, the syphon is started in its work by aspiration with a syringe, or by injecting a small amount of warm water. Better still, is warm olive oil, since it has the advantage of exciting biliary and pancreatic secretions.

When the syphon is started, the patient reclines on his right side; the tube is left in place until a complete evacuation of the bile takes place, usually in an hour. The washing then follows. A bock, with a drip apparatus, is connected to the tube. The interval needed for this washing is approximately two hours, this lapse of time being necessary to avoid nausea from distension. Two to three hundred cc. of a diluted solution of permanganate of potassium (1:1,000), of argyrol (1:5,000), of peroxide (1:1,000), or of some other antiseptic substance, may be used for the douche.

The effect of this douche is twofold: 1, mechanical sweeping; 2, light antiseptic effect on the small secondary lesions. This combination of drainage and douche should be repeated two or three times a week for about two months. The patient frequently experiences a remarkable alleviation of all his symptoms two or three days following each drainage. Furthermore, the pronounced constipation, which is the rule in these cases, is usually relieved.

As to medication per os or parenterally, there are numerous drugs to regulate the nervous system. Acetylcholin has been shown to give the best results, which confirm the suspicion that most of the intermittent stasis of the duodenum is more often of a functional, than of an organic, origin, and that the trouble is one of vago-sympathic disturbance. Acetylcholin is used in aqueous solution, intramuscularly. One centigram per day is advised until appearance of peripheric vasodilatation and bradycardia, that is to say, a subsaturation point, is reached. The acetylcholin may be given per os as a bromide (mecholyl) in a dose of 200 mlg. three times a day between meals. To avoid any toxic reactions from the use of acetylcholin, prostygmin may be given in a dose of 15 mlg. three times a day, between meals.

As these patients are usually more or less cachectic or, at least, debilitated, a strengthening regime is prescribed: meat, hydrocarbons, vitamins, mineral salts, and so forth. Fatty foods should be prohibited on account of their effect in slowing down transit in the duodenal tract. Postprandial "siestas" are advised; all physical or mental exertion of any kind is to be avoided.

EL PERIODO POST PARTUM

COMUNICACION DE 400 CASOS *

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Se ha discutido mucho el tiempo que debe durar el puerperio, y muchos tocólogos han expuesto sus ideas personales sobre esta materia. Aquí en Puerto Rico, excepto en raras ocasiones, los médicos en la práctica particular generalmente obligan a la parturienta permanecer en el lecho durante ocho o nueve días y al cabo de diez u once regresar al hogar. Este proceder según creemos es igual aquí que en los Estados Unidos. Afirma De Lee[1], que él "permite a la parida que haya tenido un parto normal, sentarse en el lecho al segundo día, abandonar éste y sentarse en una silla de extensión durante una hora, al séptimo u octavo día, y caminar al día siguiente. Si ha dado a luz en un hospital, puede retornar a su casa cuando el bebé haya cumplido diez días." Los casos operados o los que hayan tenido fiebre durante el puerperio requieren una estancia más prolongada en el lecho. Según Williams,[2] "es costumbre tradicional permitir que las paridas se sienten a los diez días, pero, en realidad, dos semanas de descanso en cama no es excesivo." Desde la época de Williams hasta el día de hoy algunos tocólogos vienen siendo partidarios de acortar el tiempo de permanencia en el lecho. Greenhill[3], por ejemplo, dice: "Yo permito a casi todas mis parturientas abandonar el lecho al octavo día del parto o antes, aún en los casos de operación cesárea o que han sufrido una laparotomía ginecológica. En realidad, les permito frecuentemente abandonar el lecho al quinto o sexto día después del parto o de la intervención quirúrgica. No he tenido que lamentarme de este proceder." Recientemente Rotstein[4], en una comunicación de 150 casos, asegura que el levantamiento de las paridas se hizo al tercero o cuarto día después del parto, sin tener en cuenta la semejanza ni la clase de parto sin haber observado malos resultados en toda su serie de casos.

En el Hospital de Distrito de Aguadilla estábamos a cargo del servicio de obstetricia, teniendo a nuestra disposición una sala de veinticuatro camas: 18 para asistencia post partum, 4 camas de parir y 2 para casos de eclampsia. Los casos infectados se aislaban en camas aparte. Como el número de camas de que disponíamos era escaso para el número de casos que teníamos que asistir, nos vimos obligados a disponer los casos en tal forma que pudiéramos acortar considerablemente el período del puerperio.

En 400 casos sin seleccionar y sin tener en cuenta su semejanza, tipo del parto, ni operaciones realizadas, tales como episiotomías, etc., administramos a todas las puérperas solamente líquidos por vía oral, y ejecutamos todas las medidas terapéuticas de rigor: inyecciones intravenosas del suero glucosado, extracto hepático, sales de hierro, etc. A cada parida se le dió a tomar una tableta de ergotrato tres veces al día durante tres días consecutivos. Si aparecían entuertos se administraba dos pastillas de aspirina y medio grano de luminal cada cuatro horas hasta que desaparecía el dolor, con lo que obtu-

* Leído ante la Asamblea Anual de la Asociación Médica de P. R., Dic. 1945.

vimos excelentes resultados. Se obligaba a la parida a acostarse boca abajo durante una hora por la mañana y otra por la tarde. Al segundo día después del parto, si la parida estaba afebril, se le daba la alimentación ordinaria. Se le permitía sentarse en el lecho en semiposición de Fowler (semideclive dorsal) durante dos horas por la mañana y dos por la tarde, con lo cual se facilitaba el drenaje de los líquidos y se aceleraba la involución uterina. A todas las paridas se les hizo amamantar al recién nacido y a las que no podían o no querían se les administró seis milígramos diarios de dipropianato de dietilstilbestrol, repartidos en dos dosis. Las fisuras o grietas en los pezones se trataron con un ungüento de sulfatiazol al cinco por ciento,teniendo cuidado de lavar los pezones con solución bórica antes de empezar la lactancia. Al tercer día del puerperio la parida se sentaba en el lecho, en posición de Fowler, todo el tiempo que quería. Durante dos días se le inyectó intramuscularmente a cada mujer, dos veces al día, medio cc. de la solución de pituitrina al milésimo, con cuyo proceder no solamente mejoraban la descarga de los loquios y la involución uterina, sino que se estimulaba la fagocitosis en el útero y el parametrio en caso de existir infección. Si al tercer día del parto no había defecación se administraba por la noche una cucharada de leche de magnesia o aceite mineral y a la mañana siguiente una enema jabonosa. Al cuarto día la parida salía del lecho, se sentaba durante un rato en una butaca, y si se sentía bien se le permitía el mismo día caminar por la sala. Al quinto día se le practicaba un examen general: aspecto de los loquios, abultamiento de las mamas, presencia de grietas en los pezones, posición de la matriz, cicatrización de los desgarres vaginales, etc. Si el nivel del útero no pasaba de tres traveses de dedo por encima de la sínfisis púbica, la parida podía irse a su casa. Si el útero sobrepasaba dicho nivel, permanecía la mujer otro día más en el hospital. A las multíparas se les aconsejó el uso de faja abdominal y ejercicios moderados para rebajar las paredes musculares.

Con esta regla de conducta uniforme en todos nuestros casos hemos podido verificar las observaciones siguientes: la involución del útero es más rápida, llegando generalmente a menos de tres traveses de dedos al quinto día, en el momento de dar de alta a la mujer. Pasado el segundo o el tercer día del alumbramiento los loquios tórnanse escasos y, en la mayoría de los casos, desaparecen al quinto día. No pudimos observar un solo caso de embolia. Unicamente tuvimos un caso de tromboflebitis leve y este ocurrió en una mujer que padecía de anemia intensa con eclampsia en el momento de ingresar en el hospital y que tuvo un parto muy laborioso, lo que nos obligó a retenerla encamada durante más de dos semanas. Todas las reparaciones de tejidos en las episiotomías y los desgarres perineales fueron ejecutadas con catgut 00, en forma de sutura entrecontada en la mucosa vaginal, y en forma de ocho de guarismo en la piel, en el elevador del ano y en la fascia del periné. La cicatrización no se retrasó lo más mínimo por el levantamiento prematuro de la parturienta. Al darlas de alta algunas conservaban aún los puntos de sutura. La enfermera se encargaba entonces de instruírlas sobre la manera de conservar el área de sus órganos genitales cubierta con apósitos estériles y cambiándolos cuando estuvieren húmedos. No tuvimos un solo caso infectado después de ser dado de alta en el hospital, y transcurridos cuarenta días, cuando venían las mujeres al hospital para hacerse el reconocimiento post partum de rigor, los órga-

nos genitales estaban en perfecto estado y el periné intacto. En una palabra: todas las recién paridas se encontraban en buen estado de salud al abandonar el hospital sin que hubiéramos observado ningún signo patológico que pudiera ser atribuído al levantamiento prematuro.

Comentario

El problema de levantar prematuramente a las recién paridas o tenerlas encamadas por espacio de ocho o diez días, según exige una venerable tradición de la práctica obstétrica, es algo en que hay que considerar múltiples factores. De un lado tenemos el factor económico, pues cuando menor sea el número de días de estancia hospitalaria menor será el coste del parto. Pero, aún así, ninguna recién parida deberá abandonar el lecho antes del cuarto día. Muchos médicos, según dicen ellos mismos, aconsejan un levantamiento del lecho en fecha aún más temprana, al segundo o tercer día, pero en estos casos, podemos asegurar que ello no es muy agradable para las mismas mujeres, quienes prefieren continuar en cama algún tiempo más. Con todo, no creemos que sean necesarios diez días de confinamiento en el lecho, pues tras este período las recién paridas se sienten mucho más débiles y mareadas. A más de esto, hay que tener en cuenta que un confinamiento prolongado puede dar lugar a una embolia pulmonar, peligro siempre existente que, en lo posible, debe prevenirse. Las mujeres, además, prefieren salir de la cama antes de cumplir diez días. Nosotros generalmente las permitimos levantarse al quinto o sexto día, y, al siguiente pasear por la habitación, caminar moderadamente en días sucesivos, hasta que al octavo o noveno día se las da de alta. En todo este asunto falta por demostrar si desde el punto de vista científico es más o menos perjudicial para las recién paridas levantarse de la cama el primero o segundo día del puerperio. Antes de dictaminar nada concluyente sobre esto habría que verificar numerosas y cuidadosas observaciones.

R. L. trad.

GRANULOMAS OF THE COLON

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Malignant tumors of the colon by far outnumber all other non-malignant neoplasms of that gut. However, there are quite a few benign, inflammatory tumors which flourish in the colon and which warrant their careful consideration. The granulomas are one of these growths.

There are two varieties of granulomas; namely, the specific granuloma, for which a definite causative agent such as the tubercle bacillus, the entameba hystolytica, the actinomyces, the streptococcus, etc., etc., is found. These particular granulomas usually involve the anus, rectosigmoid and the cecum.

The other variety is the so-called non-specific variety, to which no specific agent can be ascribed. This latter variety is most usually confused with carcinoma, sarcoma and hyperplastic tuberculosis.

Though of different etiologic and pathogenetic characteristics, these inflammatory tumors bear so close clinical and morphologic resemblances to each other, and to other malignant neoplasms inherent of this gut, that microscopic studies of the specimens become almost mandatory for their true differentiation. Roentgenologically they exhibit a filling defect like true malignant tumors, but of such characteristics that can be segregated as non-malignant by the scrutinizing eye of the experienced roentgenologist unless complicated by perforation. In this case, the concommitant inflammatory process definitely obscures the characteristic granulomatous traits.

The mutation of inflammatory benign tumors of the colon into true malignancies has been a highly controversial point in the medical literature in the last few decades. In 1927, Yemonans first described this peculiar metamorphosis and stated: "Both inflammatory hyperplasia to tumors pathologically cancerous can be traced through stages of inflammation, gland cell hypetrophy and hyperplasia, and adenoma to definite adenocarcinoma". In 1928 this view received the documented support of Bargen; and later that of Kerr, Sauer, Jackman, Streicker, Cattell, Matzner and Rankin.

On the other side of the argument, such authorities as Ewing, Swinton, Hurst, Willard, Warren and Feder have upheld their opposition to this transformation theory of Yeomans. In 1934 Ewing stated: "It is somewhat remarkable that carcinoma very rarely develops in chronic ulcerative proctitis or colitis." In 1939, Swinton and Warren wrote: "It is possible in our series to demonstrate histologically, all stages in the sequence of change from normal colonic mucosa to actual adenocarcinoma.... From a microscopic study of a large series of intestines from patients with chronic ulcerative colitis, both specimens removed surgically at varying lengths of time after unset of the disease and specimens obtained at autopsy, we believe that chronic ulcerative colitis is not a factor predisposing to the development of polyps.... In our patients with ulcerative colitis we have observed another interesting fact. Following healing of the acute ulcerative process, we have these pseudopolypoid tumors to regress and disappear... We have never observed the re-

* Paper read before a staff meeting of the 326th Station Hospital.

gression or disappearance of true polyps of the large bowel except in rare instances in which the polyp has broken away from its pedicle. This, of course, also definitely suggests that the pseudopolypoid tumors resulting from known irritation and infection have different fundamental growth characteristics than the discrete and multiple polyps which are not the result of known infectious processes... We have never observed the polypoid changes seen in ulcerative colitis progress to a malignant stage".

Lynnn, however, commits himself stating "on the average the incidence of carcinomatous degeneration of ulcerative colitis is 1.9 percent;" and Cattell has recently concluded: "At present we believe that malignancy while somewhat rare, is most frequent in patients who have had ulcerative colitis for over five years." Jackman, Bargen and Helmholz reported a series of nighty-five cases under the age of sixteen with ulcerative colitis, six of whom developed carcinoma of the colon later in life; an incidence of 6.3 percent.

This question obviously is still an intriguing and a mute one academically. Clinically and pathologically, however, these various views not merely lend support to the possibility of the transmutation of a benign lesion of the colon into a malignant one but they do strongly behoove the surgeon to consider the point in its broadest sense when tackling one of these growths.

In our presentation today we have a case of non-specific, proliferative granuloma of the descending colon to discuss. This type of the inflammatory tumor usually involves the cecum, the sigmoid and the flexures. A survey of the literature reveals only three cases of the so-called localized hypertrophic colitis affecting the descending colon reported by Ginzburg and Oppenheimer.

In reporting this case, therefore, we are moved by two prime considerations; namely, the unique nature of the growth and the rarity of its occurrence in this particular segment of the gut.

The case is that of a 25 years old, mulato, Puerto Rican soldier, who was admitted to the 326th Station Hospital on 2 April 1945, complaining of pain in the left iliac area of two months duration, specially aggravated on standing, exercising, defecation and urination.

The family, marital and past personal histories were non-contributory except for the fact that one brother died of pulmonary tuberculosis.

The man is a moderate smoker and only a light drinker and has no drug addiction. There is no history of venereal diseases, serious injuries or operation.

The account of the present illness is as follows: Two months prior to his admission at this hospital, while on training at Fort Buchanan, he was running a 60 yards race and upon its completion felt a sharp, sudden pain in the left abdominal quadrant, which was not crippling enough to force him to get help from the doctor. Three weeks later he was transferred to Camp Tortuguero for further training. At this camp, while on marches, the soldier had the pain recur ever so often gradually growing in intensity and ultimately becoming so incapacitating that often he had to linger behind the marching column.

On the last week of training at Camp Tortuguero, upon return from a night problem at Puerto Nuevo, he was siezed by a pain so awfully distressing that he had to lay on his barrack's floor yelling in agony. At this time he was taken to the dispensary of the 296th Station Hospital, Camp Tortuguero, and medicines were given to allay the pain.

Four days later, he noticed a throbbing pain in the left inguinal area, constipation, pain and burning sensation on urination.

That same week he was assigned to the Replacement Batallion and sent to Camp O'Reilly for training. At the latter station, he was detailed to attend the Cook and Bakers School.

One week after this particular phase of his training had started, the pain in the left lower quadrant of the abdomen became almost incessant and very distressing, specially on urination and defecation. There was no blood in stools and only a small amount of mucous was noticed. The soldier at this time felt a mass in the left pelvic

fossa for which he reported at sick call and was admitted to the hospital.

On admission to the surgical service of the 326th Station Hospital, we found an emaciated man who looked lots sicker than he actually complained of. The physical examination was entirely negative except for the presence of a hard, smooth mass of about 10 cm in principal diameter in the left pelvic fossa which appeared fixed to the side and base of the fossa but not to the anterior abdominal parieties or the pelvic skeleton. BP 118/72 P. 88 R.22 T 100.

The laboratory studies were negative except for mild, hypochromic normocytic anemia; a sedimentation of 26 mm; and the presence of ova of necator and trichuris in the feces. The blood serology was repeatedly negative. Frei test was negative.

A procto-sigmoidoscopic examination performed on 4 April 1945 revealed the following findings: On digital examination a smooth mass, extrinsic to the intestine was noticed at the very tip of the finger. The left seminal vesicle was distended and the posterior lobe of the prostate was boggy and large. The proctoscopic inspection revealed the mucosa to be normal for about 6 inches from the anal orifice. At this point the lumen of the intestine was obliterated and the tube could not be passed further in; the vessels appeared dilated, the mucosa was pale, edematous and gave the impression of a granulomatous or fungoid tissue. This was thought to be due to pressure on the gut and our impression was that these morphologic changes resulted probably from an extrinsic tumor pressing on the sigmoid. A barium enema was requested.

On 7 April 1945 another proctosigmoidoscopy was done and the tube inserted in its full length. No intraluminar tumor was found.

The X-ray studies were reported as follows: A flat plate of abdomen taken on 3 April 1945, was reported negative. A barium enema was done on 4 April 1945 and reported as follows. "Examination of the lower GI tract by menas of a barium enema under fluoroscopic control reveals the following: The barium fills the ampulla which is normal in size without filling defect. The lumen of the descending colon immediately above the ampulla is markedly narrowed and the barium passes thru this constricted region in a thin stream. There is, however, no distention of the bowel above the affected portion. Film reveals the same picture with the outline of the distal end of the descending colon irregular. Films with partial evacuation fail to reveal evidence of intestinal obstruction. The appendix is visualized and appears normal." X-ray of the chest done that same day failed to reveal any intra-thoracic growths or pulmonary lesion. A cystogram was done by instillation of diluted diodrast and revealed "a compression deformity at the left upper border of the bladder."

On 7 April 1945 we decided to perform a laparotomy and prepared the case as follows: The intestines were thoroughly cleaned by enemas and lavages. A high caloric, high protein, high vitamin liquid diet was ordered. A transfusion of 500 cc citrated blood was given followed by 1000 cc of 5% glucose in normal saline and sulfaguanidine (for we didn't have sulfasuccidine) started,, two gms, stat. and one gm q 4 h.

On 8 April 1945 another intestinal lavage was done and another transfusion of 500 cc citrated blood was given.

On 9 April 1945 the laparotomy was performed under spinal anesthesia. Through a left paramedian incision, the abdomen was entered. There was noticed a severe inflammatory reaction under the left rectus muscle with definitely increased vascularity. The peritoneum on the low anterior abdominal wall and pelvic fossa was found thickened to about 4 or 5 times its normal thickness, lusterless, yellowish in color and very much adherent with the transversalis fascia to the left rectus muscle. The omentum was found plastered down to the descending colon at its junction with the sigmoid in a blackish mass. There were noticed numerous infarcted glands in the mesocolon and the intestine appeared thikened. The remainder of the colon, the ileo-cecal area and the small intestines were found normal. The pelvis had a frozen-like appearance.

On the basis of the morphologic appearance of the tumor a diagnosis of neoplasm of the descending colon was made and a Dixon aseptic resection of about 5 inches of the gut with an end-to-end anastomosis was performed. The operation was completed following the Dennis technique with exteriorization of a loop of transverse colon at the mid-epigastrium.

The patient was returned to the ward under intense supportive treatment. Plasma and 5% glucose in normal saline were used liberally during the first three days. Twenty four hours after operation sulfasuccidine gms II and penicillin 25,000 U q 3h were given.

On 11 April 1945 the transverse colostomy was opened under local anesthesia. The patient was afebrile after the first twenty four hours and the highest temperature recorded was 99.6 F.

On 30 May 1945 the transverse colostomy was closed under local anesthesia. Recovery ensued normally and one month later the patient was discharged from the hospital.

The pathological report was made at the Medical Laboratory, APO 851, U. S. Army

by Captain Felix Reyes, MC, and confirmed by the Army Medical Museum Washington, D. C. It reads in part as follows: "Gross: Segment of colon measuring 10 cm in length. Its serosal surface is opaque and short tags of adhesions depend from it. A firm ovoid mass projects from its wall measuring 6 x 3 x 2 cm. Sectioning of the tumor mass and exposure of the lumen of the intestine, the following features are noted: The mucosa is intact. There is thickening of the submocosa, muscularis, and serous coats of the colon. This thickening is more conspicuous in the midportion of the resected portion of the intestine and it is several centimeters in extension. In this area the mass merges with the thickened outer coats of the intestine, it appears to be an evagination of the serous coats and longitudinal muscle layer. The cut surfaces of the mass are dense, grayish and spotted with numerous small soft yellowish focci close to one of its face margins, and close to the intestinal peritoneal surface, is a large irregular reddish-brown hemorrhagic-like area. Microscopic: Colon A, including walls of intestine and mass, longitudinal: The glandular mucous epithelium of the mucosa is swollen and its lamina propria is infiltrated by plasma cells and eosinophiles. There are two minutes discontinuities in the mucous coats. The submucosa, Muscularis and serous coats are greatly thickened and these coats have practically been replaced by granulomatous tissue thickly infiltrated by eosinophiles, lymphocytes, neutrophiles, histiocytes or large mononuclear cells. Toward the center is a sinus tract or wall of an abscess beginning in the submucosa branching out and extending into the musculous and serous coats. Its walls are thickly infiltrated by neutrophiles and other round cells. Minute aggragates of epitheliod-like cells are seen in the wall of the sinus-like tract. There is a pseudotubercle located in the submucosa immediately under the mucosa formed by giant multinucleated and epitheliod cells. The outer part of the tubercle is infiltrated by eosinophiles and one of the giant cells contains a minute yellowish refractile fragment of a schistosome egg. Abundant granulation tissue and hemorrhages are seen in the outer portion of the sections... The lymph nodules in the serous coat are hyperplastic... Giemsa's stain for virus bodies of lymphogranuloma is negative. No tubercle bacilli are demonstrated in the pseudotubercle of the submucosa... Pathological diagnosis: Granuloma, localized, non-specific, of descending colon, of unknown etiology."

In 1936 Karl A. Meyers referred to the non-specific inflammatory tumors of the gastro-intestinal tract as "medical curiosities rather than well established clinical entities." In 1939 Crohn had not found a case in the Puerto Rican population of New York.

The condition remins one of youth showing a predilection for the third and fourth decades of life. The causative agent is still elusive and unknown, thou the theory of a low grade infection of the lymphatic system has been propounded as the underlying cause. The disease is progressive, thou marked by periods of remissions and relapses, with a definite trend to chronicity. It has a special selectivity for the ileo-cecal area but cases involving the entire intestines including the duodenum and the entire colon have been reported. Usually a few segments of the gut bear the brunt of the attack with so-called "skip-areas of Crohn" betwen them at which places the intestine escapes involvement in the process.

The pathological anatomy of the disease is that of a "non-specific inflammatory process with excessive connective tissue reaction" and exudation. It can be divided into three major phases; namely, the acute phase with signs and symptoms of an acute surgical abdomen or intra-abdominal inflammation; the chronic hyperplastic phase with various degrees of stenosis of the gut and signs and symptoms of chronic obstruction; and the chronic exudative phase with development of persistent and intractable fistulae and abscess formation. The acute type may regress and resolve itself spontaneously or it may progress to the chronic form.

In the acute phase, the symptoms very closely simulate an attack of acute appendicitis or of diverticulitis; a torsion of an ovarian cyst, a mesenteric or enterogenous cyst or an epiloic appendix; or the Freeman's syndrome of acute mesenteric lymphadenitis. There are signs and

symptoms of peritoneal irritation with bouts of nausea and vomiting, fever and leucocytosis. The physical examination is otherwise negative. The X-Ray study may show a narrowing of the lumen of the colon usually attributed to a spastic condition.

The symptoms of the hyperpalstic phase are those of a low grade obstruction with cramps, abdominal distention, borborysms, and change in habit; blood and mucous in the stools; anorexia; loss of weight; moderate hypochromic anemia; persistent low grade fever, and leucocytosis. The physical examination merely discloses the presence of a mass connected to the colon. The X-ray study shows a definite stenosing of the gut with only a string of barium going through the constricted area; a sign which Kantor denominated as the "string sign" and which is analogous to the "string sign of Crane" in spastic colitis.

The symptoms of the complicated phase, the chronic exudative phase, vary with the ensuing complication but, in any event, there is definite trend toward the formation of intractable fecal fistulae and abscesses of the abdominal parietes or the pelvic floor with concomitant symptoms of pronounced sepsis. The laboratory and X-ray studies are confirmative of the clinico-pathological process.

The treatment of the disease varies with the phase of the anatomico-pathalogical envolvement. The acute phase usually resolves itself spontaneously except when the mesentery has been greatly envolved and thickened and the mesenteric glands have become enlarged and hyperplastic. In this case, the same management is carried out as in the chronic phases; namely, elimination of the envolved segments of the gut usually by resection.

The prognosis is good if ample resection is performed.

Summary: The literature is reviewed on the subject. A case of hyperplastic, stenosing, non-specific granuloma of the descending colon, in a twenty five years old, Puerto Rican soldier is presented. Attention is called to the selectivity of this type of lesion for the terminal ileum, ileo-cecal area, cecum, ascending colon, flexures and sigmoid. The pathological process usually envolves a segment in toto or various segments with so-called "skip areas of Crohn" between them. However, only three cases are reported in the literature envolving exclusively the descending colon. To these we add our case.

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DOSIS INSUFICIENTES DE PENICILINA EN EL TRATAMIENTO DE LA SIFILIS

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La sífilis, como se sabe, es una enfermedad de origen venéreo, por lo cual los enfermos la ocultan como un estigma. La incidencia ha ido aumentando gradualmente en los tiempos modernos, llegando a tales cifras los casos de esta enfermedad en los Estados Unidos, que el año 1938 el Dr. Thomas Parran, Cirujano General del "United States Public Health Service, observando la apatía en que se encontraba la nación con respecto a este padecimiento, organizó en colaboración con otros médicos la campaña más intensa que se haya hecho en los Estados Unidos en contra de esta calamidad. Al sobrevenir la guerra esta campaña estaba en todo su opogeo, y por efectos de la movilización militar se hizo más intensa.

La lesión primaria de la sífilis es el chancro sifilítico. Los autores europeos conceden una gran importancia al aspecto clínico para diferenciarlo del chancro blando y su descripción clásica se le atribuye al doctor Fournier. Actualmente no se presta mucha atención al aspecto clínico y se depende enteramente del laboratorio para el diagnóstico de la lesión primaria. Dice el doctor Stokes que cualquier lesión sospechosa o cualquier lesión en los órganos genitales debe someterse a la observación microscópica del jugo tisular en campo obscuro, para descubrir así la espiroqueta pálida y hacer el dignóstico correcto de la enfermedad.

El diagnóstico precoz del chancro sifilítico es muy importante, pues es éste el momento más favorable para su tratamiento, pudiéndose evitar el progreso de la enfermedad y las lesiones secundarias y tardías. Los arsenicales y las sales de bismuto han sido las drogas de uso corriente en el tratamiento eficaz de la sífilis y últimamente se había logrado reducir el tratamiento a una semana con el uso del arsenoxido.

Cuando el tratamiento corto e intensivo con esta droga estaba en pleno auge y se creía haber llegado al límite en sus resultados, apareció una droga que hacía maravillas: la penicilina.

En el 1941, con la visita de Florey y Heatley a los Estados Unidos bajo los auspicios de la Fundación Rockefeller, se inició la producción de penicilina en este país. Como esta droga era muy necesaria a las fuerzas armadas y su producción resultaba limitada, se la puso bajo control del gobierno y se nombró un Comité presidido por el doctor Keefer para distribuirla entre la población civil. El doctor J. F. Mahoney, Cirujano Mayor, del Servicio de Salud Pública de los Estados Unidos, Jefe del Centro de Investigaciones de Enfermedades Venéreas en el Hospital de Marinos de Staten Island, en el 1943, fué el primero en descubrir la bondad de la penicilina en el tratamiento de la sífilis. Desde entonces ésta ha sido la droga de preferencia en los casos de sífilis primaria e infecciosa. La dosis y el método de tratamiento varían y en algunas clínicas se usa la pe-

* Comunicación presentada ante la Asamblea Anual de la Asociación Médica de Puerto Rico, Diciembre 1945.

nicilina en combinación con los arsenicales. Las inyecciones intramusculares de penicilina son más efectivas en la sífilis primaria que las inyecciones intravenosas. Según Mahoney, en el método de administración que se sigue en el Ejército y la Marina de los Estados Unidos, se inyectan por lo menos 2,400,000 unidades en espacio de ocho días. Otros autores han administrado 300,000 unidades al mismo tiempo que 320 mg. de mapharsen, pero las reacciones tóxicas han obligado a descartar este último medicamento y a usar la penicilina solamente. Pero sucede que aún cuando se inyectan dosis de 3,000,000 producense recaídas. Ahora bien, con dosis bastante pequeñas, de 300,000 unidades, según el Dr. Binkley, obtiénese una rápida curación de las lesiones sifilíticas y los exámenes al campo obscuro se transforman en negativos. Estas pequeñas dosis son casi las mismas que se administran en los casos de gonorrea, pero insuficientes para la curación de la sífilis. Es este un problema muy serio que ha puesto a pensar a los médicos especialistas en enfermedades venéreas. El doctor Stokes, hablando de las excelencias de esta droga, curativa de las dos enfermedades, dice que hay que tener en cuenta que podemos estar tratando insuficientemente una infección sifilítica concomitante con una infección gonocóccica. El individuo que contrae una gonorrea puede muy bien haber adquirido al mismo tiempo la sífilis. El período de incubación de una y otra enfermedad es diferente, pero sabemos que la gonorrea es la que primero se manifiesta. Al aparecer la gonorrea el paciente recibe la dosis usual para el tratamiento de esta enfermedad, cuando la sífilis está todavía en su período de incubación. Es un hecho probado y aceptado que la cantidad de penicilina que se usa en la gonorrea (150,000 unidades) evita la aparición del chancro sifilítico y retarda su presencia por un período de tres o cuatro semanas, y, por lo tanto, elimina la prueba más temprana que existe de una infección sifilítica. Si la lesión primaria ya ha aparecido y pasa desapercibida, recibiendo el individuo tratamiento para la gonorrea, la lesión sifilítica cicatrizará, el examen al campo obscuro será negativo y tardará tres o cuatro meses en que puedan volverse a encontrar indicios de sífilis. Según Stokes, la espiroqueta desaparece en las lesiones superficiales de doce a veinticuatro horas después de una aplicación de 25,000 unidades de penicilina.

Hay otro dato muy importante también para considerar, y es la eficacia del tratamiento con penicilina en la sífilis tratada insuficientemente con esta droga. Opinan algunos autores que la sífilis tratada con dosis insuficientes de penicilina puede dar lugar a la formación de cepas de espiroquetas penicilinorresistentes, incapaces, por tanto, de ser atacadas por la nueva droga.

Si las personas que padecen de gonorrea buscaran siempre el consejo del médico, este problema no tendría mayor importancia, pero sucede que con el advenimiento de esta droga maravillosa, el público ha comenzado a aplicársela indiscriminadamente y cada día es mayor el número de pacientes que la usan sin prescripción facultativa que los que están bajo supervisión del médico. Y últimamente, con el advenimiento de la penicilina para administración por vía oral, se agudiza más el problema, pues siempre es más fácil el uso de esta vía que intramuscularmente.

Según el doctor Maxwell, con una dosis de 90,000 unidades de penicilina oral, media hora antes del desayuno, se obtiene un nivel de la droga en la sangre bastante semejante al producido por 15,000 o 20,000 unidades administradas intramuscular-

mente. De suerte que 600,000 unidades de penicilina por vía bucal, que es la cantidad que se usa para la gonorrea, produce los mismos efectos en la sífilis que 150,000 unidades de penicilina por vía intramuscular.

Para probar con datos las observaciones aquí apuntadas, vamos a mencionar tres casos de nuestra clínica.

1. R. F., mujer de 20 años de edad, casada; fué tratada de un aborto en un hospital de maternidad en los primeros días del mes de julio de 1945 y se le aplicó penicilina. Concurre a la clínica el día 19 de agosto del mismo año presentando una erupción máculopapular en todo el cuerpo y lesiones papulares en las plantas de los pies y palmas de las manos. Al interrogarla asegura haber tenido una pequeña úlcera en la vulva cuando ingresó en el hospital, que desapareció con el tratamiento de penicilina. Practicado el examen en campo obscuro de una lesión escarificada, dió resultado positivo. La serología verificada el mismo día fué francamente positiva.

2. G. M., mujer de 19 años de edad, separada del esposo, comparece a la clínica el 16 de julio de 1945. Se hizo un diagnóstico de endocervicitis gonocóccica aguda; no se encontró lesión sospechosa de sífilis.

Se le aplicaron 150,000 unidades de penicilina el 17 de julio y se le ordenó regresar a los tres días. La enferma no regresó hasta el día 30 de agosto del mismo año, presentando entonces lesiones de sífiles secundaria de cinco días de duración. No se pudo comprobar la existencia de lesión primaria. La enferma negó haber tenido contacto sexual desde la primera consulta, asegurando que desde esa fecha no había vuelto porque se sentía bien. El examen al campo obscuro dió resultado positivo y también la serología.

3. R. B., varón de 22 años de edad, soltero hace dos meses padecía unas úlceras en la garganta y un médico le aplicó 200,000 unidades de penicilina. Hace diez días le apareció una erupción en todo el cuerpo. No ha tenido contacto sexual en los últimos dos meses. Al examinarle presentaba una pequeña lesión en el prepucio. El examen al campo obscuro dió resultado positivo y también la serología.

En la Clínica de Enfermedades Venéreas donde trabajamos, hemos dado orden de que todo caso de gonorrea tratado con penicilina, con serología negativa, debe regresar mensualmente por un período de cuatro meses para que se le tomen muestras de sangre y practicar las pruebas necesarias para determinar la existencia de sífilis.

Nos hemos propuesto principalmente en este modesto trabajo llamar la atención de los compañeros médicos sobre la necesidad de observar los enfermos aquejados de gonorrea que hayan sido tratados antes con penicilina, pues no debe olvidarse que una cantidad insuficiente de este medicamento evita o retarda la aparición de la lesión diagnóstica de la sífilis.

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INFORMES DE CASOS

"PASSIVE" EXTRAPERITONEAL RUPTURE OF THE BLADDER DUE TO AN OBSTRUCTIVE CARCINOMATOUS PROSTATE

REPORT OF ONE CASE

LUIS A. SANJURJO, M. D.

Before attempting the presentation and discussion of this case, we desire to introduce a new term to define more clearly and with adequate precision, those ruptures of the bladder that occur in the absence of injuries. Among those are comprised bullet and stab wounds; perforations of the bladder by fractures of the adjacent bony structures and instrumentation during various surgical procedures; also those produced by falls, kicks or blows over the suprapubic area. The former are catalogued in the medical nomenclature as wounds of the bladder, the latter as traumatic rupture of the viscus.

The term "spontaneous", when applied to rupture of the bladder has been extensively used to include these ruptures occurring in the absence of external violence and surgical instrumentation. This term, we believe, is not adequate. The Webster Dictionary explains "spontaneous" as "acting by its own impulse, energy or natural law."

The so called spontaneous rupture of the bladder occurs when there is obstruction to the normal outflow of urine with overdistention besides ulcerative processes, infection, tumors, congenital conditions or neurogenic disturbances of the bladder. It is obvious that a bladder cannot rupture itself by its own impulse and energy, unless concomitant pathological factors will render a laceration possible. We would like to introduce the term "passive" when applied to this group of ruptures of the bladder as more adequate and correct. "Passive" is defined by Webster as "unresistant, not opposing, receiving or suffering without resistance" and as "applied to certain morbid conditions marked by relaxing of the nerves and tissues and decrease in vitality."

We all have seen, tremendously dilated bladders by atonia or obstruction of various natures without rupture. In practically all instances, when a bladder ruptures without external violence or instrumentation, some pathological condition of the bladder wall exists. These same conditions are currently seen in daily medical practice without bladder rupture. The association of obstruction and distention plus weakening of the bladder wall by some form of disease, are necessary factors, in order to have a rupture. We do not imply that when these factors are present in one individual a rupture of the bladder necessarily occurs. The rarity of these conditions shows clearly the opposite.

Cahill[1] has stated that it occurred 1 in 5,550 cases among 330,000 surgical admissions to the Bellevue Hospital.

There are three varieties of bladder rupture regardless of its etiology: (a) intraperitoneal; (b) extraperitoneal; (c) a combination of both. The rupture usually takes place along the lines of least resistance; the dome and posterior wall, which are devoid of strong anatomical support, are usually affected.

Any type of bladder rupture is a serious major surgical problem. The intraperitoneal variety usually is complicat-

ed by peritonitis. The extraperitoneal variety is complicated by extravasation of urine of a major or lesser degree. When the tear on the viscus opens inside the peritoneal cavity and outside of it, peritonitis and urine extravasation take place. Among these varieties of rupture, the extraperitoneal is less frequent, as those parts of the bladder not covered by the peritoneum, are protected by the ligaments and fascias, the bony pelvis acting as a support.

Any early diagnosis and prompt surgical treatment are of paramount importance, as the mortality rate increases progressively with each hour of conservative or expectant treatment.

REPORT OF CASE

Mr. E. R., a 74 years old white male of French descent, from Fort de France, Martinique, W. I., arrived in San Juan, Puerto Rico by plane on May 27, 1945. The patient was accompanied by his wife, daughter, and the family physician who gave us the following history, helped at times by the patient himself, who later corroborated their statements.

In 1939 while on a visit to Paris, he went to see Professor G. Marion for symptoms of prostatism of five years duration. The patient was informed that he had a large benign tumor of the prostate gland and accepted a suprapubic enucleation that was done in two stages. The postoperative course was uneventful and the patient continued his pleasure trip through France.

The patient felt perfectly well until early in 1943 when began to have some difficulty in voiding his urine and noticed that urinary stream was losing its force. He had slight frequency during daytime and during the night he had to wake up twice to pass a small amount of urine He was seen by the family physician in Martinique who gave him some medication with practically no improvement.

By mid 1944 his symptoms had slowly but progressively become worse. He voided 10 to 12 times during the day and 5 to 6 times during the night having always the sensation of a full bladder. The force of the urinary stream was greatly reduced and needed to strain considerably. There was mild intermitent dribbling and burning during and after urination.

There was no urologist in Martinique and on account of the war and the blockade of the island, this patient, a well to do businessman could not seek adequate medical care somewhere else.

In April 1945 the patient could hardly void, and only after severe straining, was able to pass small quantities of dark foul urine. He ran a low grade fever, had lost his appetite and was feeling depressed and worried about his condition. He had lost over 20 pounds.

On May 10, 1945 he went into complete retention of urine. Attempts to pass some catheters failed and that same night the lower end of the old suprapubic incision burst open draining a large amount of foul smelling, purulent, bloody urine. He felt much better afterwards; his temperature remained however oscillating between 39º and 39.5º C.. He was treated conservatively and 17 days later arrangements were made with the corresponding gevernments to send this patient to Puerto Rico by plane.

The patient arrived by stretcher in a critical condition. He appeared toxic, dehydrated and nauseated.

The physical examination revealed the following: Vision corrected by glasses, moderate bilateral deafness and otosclerosis. Upper and lower dentures. Fine

bronchial rales scattered throughout both pulmonary fields. The heart sounds were diminished and had a good tone and rythm, no murmurs or thrills were found; B. P. 137/82. The abdomen was soft, no tenderness found. A well healed mid suprapubic scar was present. On the lower end of the scar there was an area of necrotic tissue about 1 cm. wide from which purulent foul smelling urine drained.

External genitalia was not remarkable. The rectal examination revealed a good sphincter tonus and a grade A prostatic enlargement. The gland was of stone like hardness and of irregular shape and surface. The area of induration extended towards the seminal vesicles. The skin was dry. Musculo-skeletal system negative. Tendinous cutaneous reflexes were active bilaterally.

The suprapubic sinus was probed with silk woven filiforms and a straight sinus down to the bladder fund. This sinus admitted a H 12 F. Nelaton catheter and this was left in situ to establish a direct bladder drainage.

The laboratory examinations were as follows: The red cell count and hemoglobin were within normal limits. The W. B. C. 15,000 with 90% polys. The urine was loaded with W.B.C. and R.B.C. and Gram positive reds later identified as B. Coli. Blood chemistry: N.P.N. 75; Urea N. 35; Creatinine 2. The P.S.P. test was 25% elimination in one hour. The alkaline and acid serum phosphates were 12 and 8 respectively. Modified Bodanski units. X-rays of long bones, pelvis and spine showed arthritic changes but no suggestion of skeletal metastasis. A K.U.B. showed no calculi. The E.K.G. was within normal limits.

The patient was treated conservatively. The fluid intake was maintained over 3,000 cc. daily completed by intravenous infusions. Sulfathiazole 1 gm.q.i.d. were given and 5 mgs. of Stilbestrol by mouth daily. The patient's condition rapidly improved. Physically and mentally the patient felt well. Ten days after admission a subcapsular bilateral castration was done under local infiltration anesthesia.

The operative wound healed well and the patient was discharged from the clinic 30 days after admission, walking. He was instructed to return in 4 months for a prostatic resection. He was fitted with a rubber urinal.

In August 1945 the patient returned to Puerto Rico. By this time he had gained all his lost weight, felt strong and attended to his business satisfactorily. He was tolerating 5 mgs. of Stilbestrol daily. The prostate this time was softer than when first examined three months before and appeared to be enlarged grade one. The infiltration towards the seminal vesicles persisted but to a lesser degree. The urine showed occasional red and white cells but a large amount of Gram positive reds were present. The blood chemistry was: N. P. N. 44.44; Urea N. 21.21; uric acid 3.4; creatines 1.4; Sugar 97 CO 2, combining power 68; Serum acid phosphatase 2 units; alkaline phosphatase 6. Bodanski units. X-ray of bones showed no metastasis.

A transurethral resection was done under low spinal anesthesia 100 mgms. novocaine crystals. About 20 gms. of tissue were removed. The postoperative course was uneventful. The suprapubic sinus healed in 5 days. When the urethral catheter was removed on the third postoperative day the patient was able to void freely and to completely empty his bladder. The patient writes to us once a month and continues to feel well. Voids freely. The urine is free of pus cells and bacteria and he is in full charge of all his affairs.

The pathological report of the tissue removed, submitted by Dr. E. Koppisch, of the Department of Pathology of the School of Tropical Medicine was "Adenocarcinoma of the Prostate."

COMMENTS

As has been stated in the above history, the rupture of the bladder occurred in the presence of a markedly chronic distended bladder due to obstruction by a carcinomatous prostate. The bladder ruptured extraperitoneally through the line of the old suprapubic scar that was probably far stretched by an unquestionably distended viscus. This patient did not have urinary extravasation of great magnitude as the scar tissue from his suprapubic operation probably walled off and cannalized the urine externally.

This is the only logical explanation we can find for the survival of this old gentleman despite having a serious urological complication. Culp[2] on his tabulation of the mortality in cases of extraperitoneal rupture of the bladder gives a mortality of 100% in cases that were not operated upon.

As mentioned before this patient did not receive adequate urological attention until the 17th day after the rupture of his bladder. Even then, his critical condition did not allow even to do a suprapubic drainage and we satisfied ourselves to drain the bladder with a catheter utilizing the straight fistulous tract, which was large enough to permit the passage of a H 12 F rubber catheter. Later on catheters up to 18 F were easily passed and seemed adequate to drain his bladder.

CONCLUSIONS

1. The term "passive" when applied to rupture of the bladder is offered, instead of the term "spontaneous."

2. One case of extraperitoneal rupture of the bladder, of the so called spontaneous variety is reported with survival of the patient although no surgical treatment was given until the 17th day after rupture.

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AORTA DEL LADO DERECHO

PERSISTENCIA DEL PEDICULO DEL CUARTO ARCO BRANQUIAL

INFORME DE UN CASO

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Normalmente, el cuarto arco branquial izquierdo en el desarrollo embriológico de los grandes vasos, sirve de base para la formación definitiva de la aorta, mientras el derecho forma la arteria innominada. El segmento de la aorta dorsal derecha entre la subclavia y la aorta dorsal común, desaparece y el resto del cuarto arco branquial sirve de base para la arteria subclavia derecha.

En la anomalía que se conoce con el nombre de aorta del lado derecho, el cuarto arco branquial izquierdo sufre una casi total obliteración, exceptuando un pequeño divertículo en su posición distal, que sirve de base para el desarrollo de la subclavia izquierda. La comunicación entre la dorsal común y el cuarto arco branquial persiste, formando de ese modo el arco del lado derecho, que localizado detrás del esófago y la tráquea puede producir todo el desplazamiento, que el tamaño del divertículo sea capaz de producir.

Casuística

Un paciente de 27 años de edad, es admitido al Hospital en abril 17 de 1944, con un diagnóstico de posible úlcera péptica. Los síntomas clínicos habían comenzado ocho años antes, y estaban relacionados con severos disturbios emocionales durante su vida civil.

Durante los últimos ocho años, el paciente recuerda haber tenido numerosos episodios de dolores epigástricos, que no se aliviaban con la ingestión de alimentos ni estaban acompañados de hambre dolorosa nocturna. No recuerda haber tenido vómitos y no ha tenido pérdida de peso. No sabe precisar si ha tenido evacuaciones negruzcas. Durante los últimos dolores ha sentido una sensación de desfallecimiento cuando trataba de combatirlos rehusando el alimento. El ayuno no parecía aliviarlo. Los dolores no se reflejaban hacia el hombro ni hacia las vértebras dorsales. No había disfagia.

El examen físico revela una cicatriz en en punto de McBurney, consecutiva a una operación de apendicitis hace seis años. Por lo demás es irrelevante. La orina es normal. El estudio de la sangre demuestra un contaje absoluto y diferencial dentro de límites normales. El contenido gástrico revela 5, 15 y 70 unidades de ácido libre. El examen de las heces reveló sangre oculta y presencia de bilharzia.

El estudio colecistográfico no reveló anormalidad alguna; el gastrointestinal demuestra un desplazamiento y estrechamiento del esófago al nivel de la cuarta dorsal. El resto del estómago no demuestra patología alguna.

Discusión

Los primeros observadores que lograron identificar por medio de la exploración radiológica esta anormalidad anatómica fueron Assmann[1], Arkin[2], y Biedermann[3] en 1924, 1926 y 1931 respectivamente. Según Spencer y Dresser[4], con antelación a esta fecha, ya Albracht en

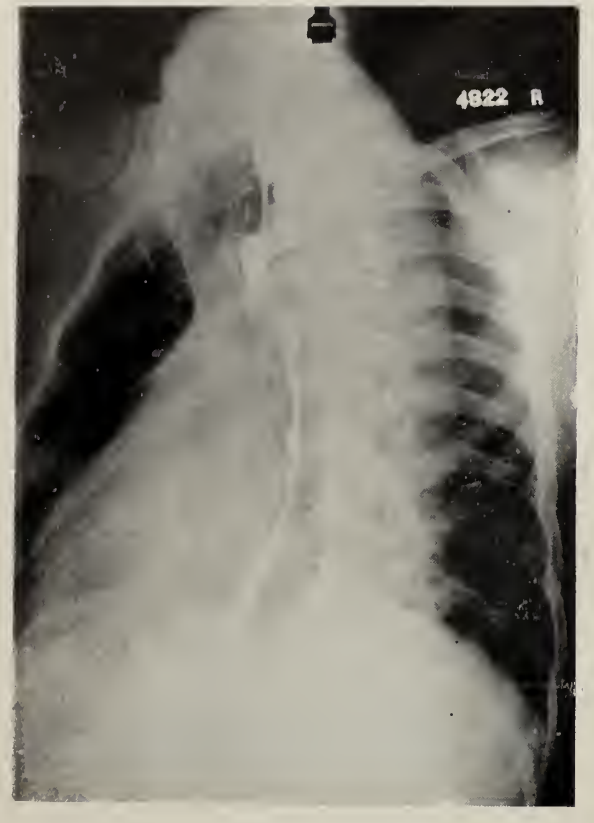

FIG. 1.
Posición oblicua derecha. Deformidad típica de la sombra esofágica.

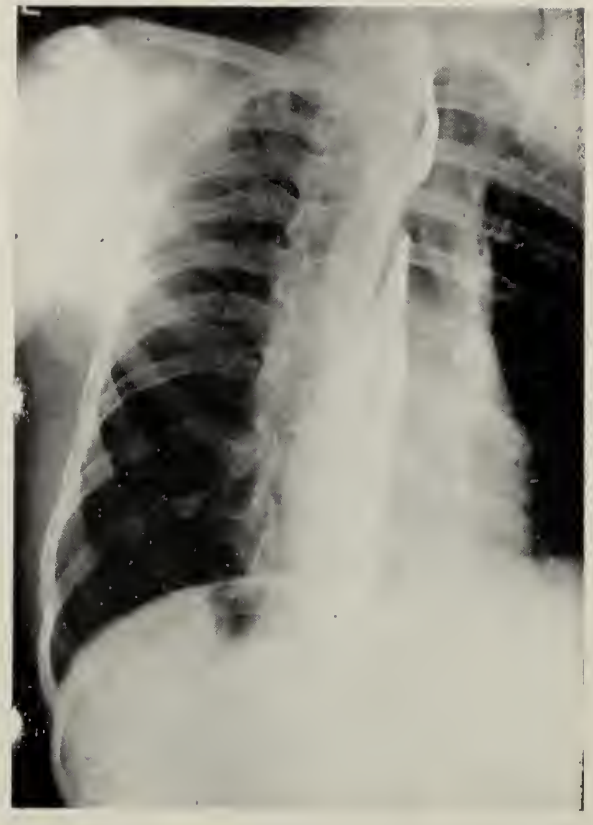

FIG. 2.
Posición oblicua izquierda. Deformidad típica con estrechez distal.

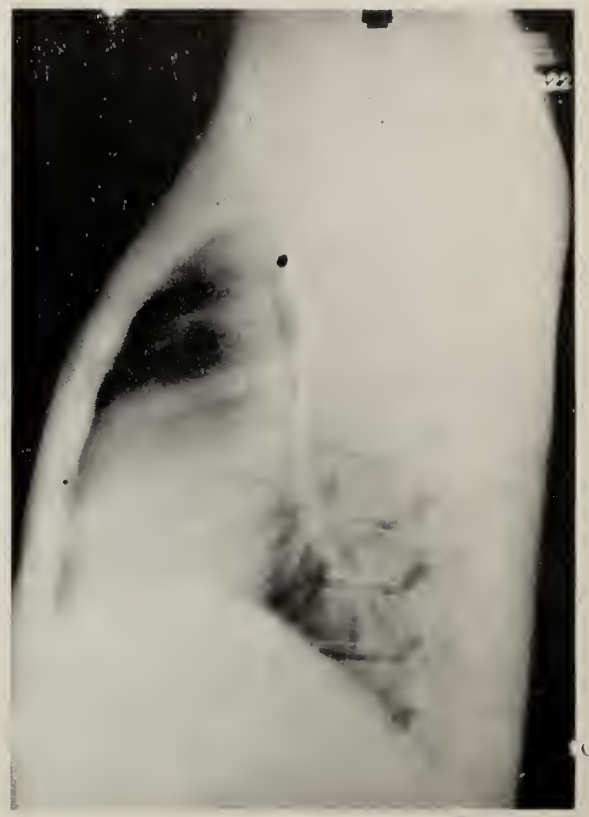

FIG. 3.
Posición lateral derecha. La sombra del esófago presenta además de la deformidad, aparente dilatación del segmento superior.

Colaboración con Assmann la habían diagnosticado, en un caso, que luego Mohr en 1913 confirmó en la autopsia y describió en el mismo año.

La primera observación que se hizo en lengua inglesa, fué la de Renander en 1926, pero que publicada en Acta Radiológica de Escandinavia, fué escasamente conocida y comentada. En 1932, Blackford, Davenport y Bayley[5], informaron un caso, y analizaron un grupo de 100 casos que lograron identificar en una cuidadosa búsqueda de la literatura. En 1933, Sprague, Ernlund y Albright[6] informaron dos casos, y discutieron ampliamente el aspecto clínico, llamando la atención sobre la disfagia, disnea, cianosis, tos y ronquera, como síntomas predominantes en numerosos casos.

Spencer y Dresser, ya anteriormente citados, informaron en 1936 tres casos, dos de los cuales habían sido referidos para radioterapia, con un diagnóstico de enfermedad de Hodgkin. El tercer caso, fué diagnosticado durante la investigación de una posible úlcera duodenal.

En nuestro caso, donde el desplazamiento del esófago por el pedículo del cuarto arco branquial es obvio, no había disfagia, cianosis, tos ni ronquera. En sus manifestaciones posteriores y durante la persistente investigación de síntomas posiblemente olvidados, informó que en algunas ocasiones había sentido ligera dificultad en la ingestión de los alimentos.

En la revisión de la literatura, los casos asintomáticos e identificados durante la investigación fluoroscópica, son numerosos. Posiblemente el divertículo que se forma por la persistencia del pedículo branquial, no siempre se desarrolla en forma y tamaño que produzca además de la deformidad, síntomas definitivos de compresión.

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TOXIC EFFECTS OF PENICILLIN TREATMENT IN PREGNANT WOMEN

JORGE GARCIA-BIRD, M.D.
Santurce, P. R.

Recently there has been many reports in various medical journals of the toxic effects of Penicillin in pregnant women. Leavitt and Lentz have reported that penicillin may cause abortions in pregnant women, especially if large doses are given from the beginning. This they ascribed to the apparent but ill-defined relationship between the mold of Penicillin and ergot, a biologic product of another mold (Claviceps purpurea. They suggest that in treating syphilitic pregnant women, it may be best to reduce the penicillin dosage considerably during the first thirty-six to forty-eight hours. No abortions have been reported when penicillin is used in this way.

Recently I have had two cases in which penicillin was given during the first three months of pregnancy and abortion occurred ten to fourteen days afterwards without any apparent cause and which could be readily blamed on the penicillin given to these two patients.

REPORT OF CASES

1.—O. C. M., 17 years old. When first seen in my office, patient presented several condylomata acuminate and a large chancre in the labia majora. Patient was three months pregnant. Penicillin treatment was started: 100,000 units in oil and wax were given daily in one injection. A total dose of 2,500,000 units was given. Chancre disappeared and so did the condyloma acuminate. About fourteen days after the treatment with penicillin had been stopped, patient developed low abdominal pain and spotting by vagina. Patient was immediately sent to bed, with ice bag to lower abdomen, 10 mg. of Proluton daily and 50 mg. of Tocopherex three times a day. After two days of this treatment and seeing that pain and bleeding increased, patient was taken to operation room and products of conception which were protruding from a dilated cervix were removed with the ovum forceps. Recovery was complete.

2.—The second case followed more or less the same pattern. I believe that with such reports coming in every day, doctors should be very careful when administering penicillin to the pregnant women and if the treatment is necessary as in syphilitic pregnancies, the dosage initially should be reduced considerably. In this way the action of penicillin on the uterus will be minimized and many abortions prevented.

CONFERENCIA CLINICO-PATOLOGICA DEL HOSPITAL DE DISTRITO DE BAYAMON - MAYO 21 DE 1946

Caso 43407 A. 435

Presentación del Caso

Una enferma de 50 años de edad, ingresó en el Hospital el 28 de febrero de 1946, quejándose de malestar epigástrico, pérdida de peso y pérdida de fuerzas. Presentaba además pronunciada hinchazón del vientre. Este cuadro que databa desde hacía 4 meses, venía también acompañado por náuseas y vómitos, y desde un principio por evacuaciones negruzcas. No hay información de que hubiera pérdida de apetito.

El examen físico demostraba una señora afectada por una dolencia crónica, notablemente desnutrida y emaciada. La cabeza y el cuello no revelaban ninguna anormalidad. Los campos pulmonares eran claros y normales. El corazón no revelaba prominencia alguna y los sonidos eran de volumen, velocidad y ritmo normales. El abdomen presentaba notable distensión y se apreciaban ondas de líquido conjuntamente con matidez en los flancos. No había masa palpable. Había notable sensibilidad a la palpación profunda. No se apreciaba aumento de volumen del hígado y bazo. Las extremidades no acusaban edema. La temperatura 36.2º C., pulso 76, respiración 28.

Los exámenes de laboratorio demostraron 2,830,000 eritrocitos, 5,000 blancos, con 52% de hemoglobina. El contaje diferencial reveló 64% segmentados, 8% eosinófilos y 28% linfocitos. La orina color amarillo, gravedad específica 1005, albúmina negativa, azúcar negativo, sedimento recargado de uratos amorfos. La sangre: proteínas totales 5.68, albúmina 3.16, globulina 2.52. Van den Bergh indirecto 0, N. P. N. 85.7 mgs., colesterol 187 mgs. Cultivo de la excreta negativo.

El líquido obtenido de la paracentesis, practicada al poco tiempo de su admisión, reveló un color pajizo y una gravedad específica de 1.012.

La hospitalización de esta enferma estuvo caracterizada por una contínua sensación de mareos y frecuentes episodios de vómitos, siendo casi nula la alimentación y administración de medicinas.

Finalmente, en marzo 11, tuvo severos vómitos de sangre, falleciendo en marzo 12, a los trece días de hospitalización.

Diagnóstico Diferencial

Dr. J. R. Ramos Mimoso

Este es el caso de una señora de 50 años, y que durante los últimos cuatro meses, sin profunda anorexia, ha venido perdiendo las fuerzas progresivamente, se ha adelgazado, ha tenido deposiciones negras, y se le ha ido "inflando el vientre." Fué admitida al Hospital en febrero 28, habiendo expirado en marzo 12 del mismo año, con un cuadro de hematemesis, melena y shock.

El examen físico demuestra que esta señora tenía una caquexia marcada. Su vientre estaba abultado pero no tenía evidencia de edema ni en la cara ni en las extremidades. Su presión arterial era de 180/110 y el abultamiento del vientre se debía a una ascitis, la cual requirió urgente paracentesis. Los exámenes de laboratorio no proporcionan ayuda definitiva a menos que no consideremos el valor negativo de los mismos: orina normal; anemia microcitaria; colesterol de 187 mg.

que está dentro de los límites normales; reacción de Van den Bergh en cero; proteínas totales del suero ligeramente bajas, pero sin alteración en la proporción albuminoglobulina, N. P. N. de 87 mg. y una curva de glicemia plana.

Al considerar el diagnóstico diferencial en casos como éste donde la ascitis y la hemorragia gastrointestinal son los signos preponderantes, hemos de considerar dos condiciones primordialmente, a saber:

1. La cirrosis hepática y el síndrome de hipertensión portal.
2. Tumores malignos del aparato gastrointestinal.

La cirrosis hepática y el síndrome de hipertensión portal pueden considerarse conjuntamente, pues en ambos coinciden el factor hipertensión portal como causa primordial de la ascitis aunque el verdadero mecanismo fisio-patológico varíe en otros aspectos.

Para hacer un diagnóstico de cirrosis hepática tenemos que demostrar la participación del hígado en el proceso. La reacción de Van den Bergh negativa directa o indirecta; el valor de colesterol normal; y la falta de alteración en la proporción de albuminoglobulina, son las únicas pruebas que tenemos ante nuestra consideración, y todas ellas son contrarias a indicar que el hígado está en falta. El hecho de que se puede interpretar la hematemesis final de esta paciente y las hemorragias gastrointestinales que tuvo durante el período de su enfermedad como producidas por flebectasias esofágicas y que estas flebectasias fuesen parte del cuadro de la cirrosis hepática, nos llevan a examinar la participación del bazo en este proceso. De todos es conocido que el aumento de volumen del bazo por congestión en la cirrosis hepática es el que da lugar a la formación de estas flebectasias, tan es así, que el tratamiento de ellas nunca es directo sobre las flebectasias en sí, y sí indirecto, por medio de la extirpación del bazo. En este caso el bazo no era palpable y al parecer no estaba agrandado. Además, el síndrome de hipertensión portal está caracterizado por esplenomegalia, ascitis e hipotensión arterial, y aquí no tenemos nada más que la ascitis. La presión arterial está alta 180/110, la cual interpretamos sobre bases arterioescleróticas.

Se ha hablado de que posiblemente la fase final haya sido la de un síndrome hepatorenal. Es cierto que el N. P. N. es de 87 mg., lo cual es índice de un estado urémico. Pero esta uremia en ausencia de otros signos y hallazgos de laboratorio como el de la orina, y que ya hemos visto fué negativo, hemos de considerarla como la urenia que se produce en la hemorragia profusa del tracto gastrointestinal. Aquí no hay duda han habido esas hemorragias. Hace ya algún tiempo hemos estado considerando los valores de N.P.N. durante las hemorragias gástricas agudas para hacer el pronóstico. El síndrome hepatorenal va precedido casi siempre (podría decir que el 99% de las veces) de estados ictéricos más o menos violentos; señal de grave lesión hepática. En este caso la clínica y el laboratorio han coincidido para absolver al hígado de culpabilidad. Descartamos pues el síndrome de hipertensión portal, cirrosis hepática y síndrome hepatorenal como fase final.

Nos queda por considerar el cáncer. Las hematemesis, las melenas, la caquexia y el curso rápido en la evolución de esta enfermedad favorecen el diagnóstico de cáncer del estómago. La ascitis se explica por metástasis a la cavidad peritoneal; el N. P. N. alto por la absorción de sangre del trayecto gastrointestinal produciendo una toxemia urémica.

Diagnóstico Clínico

1. Cirrosis del hígado
2. Ruptura de várices esofágicas
3. Síndrome hepato-renal
4. Anemia secundaria a la cirrosis

Diagnóstico clínico del Dr. Ramos Mimoso

1. Cáncer del estómago
2. Uremia secundaria a la hemorragia del tracto gastrointestinal.

Diagnóstico anatómico

Dr. Félix M. Reyes

1. **Nefroesclerosis arteriolar,** estado avanzado.
2. Gastritis aguda urémica.
3. Ulceras urémicas del estómago, agudas y sangrantes.
4. **Hemorragia del estómago** (hematemesis) debido a (3)
5. Colitis urémica, leve.
6. Pericarditis urémica, leve.
7. Hipertrofia del corazón, secundaria a hipertensión arterial.
8. Congestión pasiva pulmonar, del bazo, hígado, páncreas, riñones y glándulas suprarenales; y ascitis.

Discusión

Este es un caso de **nefroesclerosis arteriolar** e hipertensión arterial (180/100), en una hembra de color y 50 años de edad, con un cuadro final de decompensación renal y uremia (N.P.N. 85.7) y muerte debido a hemorragia gástrica consecutiva a úlceras urémicas sangrantes del estómago, situadas en la región cardíaca y originadas sobre una gastritis aguda urémica. Cambios leves urémicos se notaron también en el pericardio y mucosa del colon. La hipertrofia del corazón fué consecutiva a una hipertensión esencial asociada con una arterioloesclerosis benigna principalmente renal y menos severa en otros órganos como el bazo y páncreas.

INTERNAL MEDICINE AS A VOCATION*

It was with the greatest pleasure that I accepted an invitation to address this section of the Academy on the importance of internal medicine as a vocation. I wish there were another term to designate the wide field of medical practice which remains after the separation of surgery, midwifery, and gyneacology. Not itself a specialty (though it embraces at least half a dozen), its cultivators cannot be called specialists, but bear without reproach the good old name physician, in contradistinction to general practitioners, surgeons, obstetricians, and ginecologists, I have heard the fear expressed that in this country the sphere of the physician proper is becoming more and more restricted, and perhaps this is true; but I maintain (and I hope to convince you) that the opportunities are still great, that the harvest truly is plenteous, and the labourers scarcely sufficient to meet the demand.

At the outset I would like to emphasize the fact that the student of internal medicine cannot be a specialist. The manifestations of almost any one of the important diseases in the course of a few years will "box the compass" of the specialties. Typhoid fever, for example, will not only go the rounds of those embraced in medicine proper, but carry its student far afield in morbid psychology, and sometimes teach him, perhaps at the cost of the patient, a little surgery. So, too, with syphilis, which after the first few weeks I claim as a medical affection. I often tell my students that it is the only disease which they require to study thoroughly. Know syphilis in all its manifestations and relations, and all other things clinical will be added unto you.

Each generation has to grow its own consultants. Hossack, Samuel Mitchill, Swett, Alonxo Clark, Austin Flint, Fordyce Barker, and Alfred Loomis, served their day in this city, and then passed on into silence. Their works remain; but enough of a great physician's experience dies with him to justify the saying "there is no wisdom in the grave." The author of **Rab and His Friends** has a couple of paragraphs on this point which are worth quoting: "Much that made such a man what the community,to their highest profit, found him to be, dies with him. His inborn gifts, and much of what was most valuable in his experience, were necessarily incommunicable to others; this depending much on his forgetting the process by which, in particular cases, he made up his mind, and its minute successive steps,... but mainly, we believe, because no man can explain directly to another man how he does any one practical thing, the doing of which he himself has accomplished not at once or by imitation, or by teaching, but by repeated personal trails, by missing much before ultimately hitting."

Wherewithal shall a young man prepare himself, should the ambition arise in him to follow in the footsteps of such a teacher as, let us say, the late Austin Flint — the young man just starting, and who will from 1915 to 1940 stand in relation to the profession of this city and this country as did Dr. Flint between 1861 and the time of his death. We will assume that he starts with equivalent advantages, though this is taking a great deal for granted, since Austin Flint had a strong hereditary bias toward medicine, and early

* Sr. William Osler, Late Regius Professor of Medicine, Oxford, and Late Honorary Professor of Medicine, Johns Hopkins Univertity, delivered this famous address in 1897 before the New York Academy of Medicine.

in life fell under the influence of remarkable men whose teachings moulded his thought to the very end. We must not forget that Dr. Flint was a New Englander, and of the same type of mind as his great teachers—James Jackson and Jacob Bigelow.

Our future consultant has just left the hospital, where, for the first time realizing the possibilities of his profession, he has had his ambition fired. Shall he go abroad? It is not necessary. The man whom we have chosen as his exemplar did not, but found his opportunities in country practice, in Buffalo and Louisville, then frontier towns, and in New Orleans, and had a national reputation before he reached New York. But would it be useful to him? Undoubtedly. He will have a broader foundation on which to build, and a year or two in the laboratories and clinics of the great European cities will be most helpful. To walk the wards of Guy's or St. Bartholomew's, to see the work at the St. Louis and at the Salpetriere, to spend a few quiet months of study at one of the German University towns will store the young man's mind with priceless treasures. I assume that he has a mind. I am not heedless of the truth of the sharp taunt.

How much the fool that hath been sent to Rome,
Exceeds the fool that hath been at home.

At any rate, whether he goes abroad or not, let him early escape from the besetting sin of the young physician, **Chuvinism**, that intolerant attitude of mind, which brooks no regard for anything outside his own circle and own school. If he cannot go abroad let him spend part of his short vacations in seeing how it fares with the brethern in his own country. Even a New Yorker could learn something in the Massachusetts General and the Boston City Hospitals. A trip to Philadelphia would be most helpful; there is much to stimulate the mind at the old Pennsylvania Hospital and at the University, and he would be none the worse for a few weeks spent still farther south on the banks of the Chesapeake. The all-important matter is to get breadth of view as early as possible, and this is difficult without travel.

Poll the successful consulting physicinas of this country to-day, and you will find they have been evolved either from general practice or from laboratory and clinical work; many of the most prominent having risen from the ranks of general practitioners. I once heard an eminent consultant rise in wrath because some one had made a remark reflecting upon this class. He declared that no single part of his professional experience had been of such value. But I wish to speak here of the training of men who start with the object of becoming pure physicians. From the vantage ground of more than forty years of hard work, Sir Andrew Clark told me that he had striven ten years for cakes and ale; and this is really a very good partition of the life of the student of internal medicine, of some at least, since all do not reach the last stage.

It is high time we had our young Lydgate started.[1] If he has shown any signs of nous during his student and hospital days a dispensary assistanship should be available; anything should be available; anything should be acceptable which brings him into contact with patients. By all means, if possible, let him be a pluralist and — as he values his future life —

1. This well-drawn character in George Eliot's *Middlemarch* may be studied with advantage by the physician; one of the most important lessons to be gathered from it is—marry the right woman!

let him not get early entangled in the meshes of specialism. Once established as a clinical assistant he can begin his education, and nowadays this is a very complicated matter. There are three lines of work which he may follow, all of the most intense interest, all of the greatest value to him — chemistry, physiology, and morbid anatomy. Professional chemists, look askance at physiological chemistry, and physiological chemists criticize pretty sharply the work of some clinical chemists, but there can be no doubt of the value to the physician of a very thorough training in methods and ways of organic chemistry. We surely want, in this country, men of this line of training, and the outlook for them has never before been so bright. If at the start he has not had a good chemical training, the other lines should be more closely followed.

Physiology, which for his will mean very largely experimental therapeutics and experimental pathology, will open a wider view and render possible a deeper grasp of the problems of disease. To Traube and men of his stamp, the physiological clinicians, this generation owes much more than to the chemical or **post-mortem**-room group. The training is more difficult to get, and nowadays, when physiology is cultivated as a specialty, few physicians will graduate into clinical medicine directly from the laboratory. On the other hand, the opportunities for work are now more numerous, and the training which a young fellow gets in a laboratory controlled by a pure physiologist will help to give that scientific impress, which is only enduring when early received. A thorough chemical training and a complete equipment in methods of experimental research are less often met with in the clinical physician than a good practical knowledge of morbid anatomy; and, if our prospective consultant has to limit his work, chemistry and physiology should yield to the claims of the dead-house. In this dry-bread period he should see autopsies daily, if possible. Successful knowledge of the infinite variations of disease can only be obtained by a prolonged study of morbid anatomy. While of special value in training the physician in diagnosis, it also enables him to correct his mistakes, and, if he reads its lessons aright, it may serve to keep him humble.

This is, of course, a very full programme, but in ten years a bright man, with what Sydenham calls "the ancient and serious diligence of Hippocrates", will pick up a very fair education, and will be fit to pass from the dispensary to the wards. If he cannot go abroad after his hospital term, let it be an incentive to save money, and with the first $600 let him take a summer semester in Germany, working quietly at one of the smaller places. Another year let him spend three months or longer in Paris. When schemes are laid in advance, it is surprising how often the circumstances fit in with them. How shall he live meanwhile? On crumbs — on pickings obtained from men in the cakes-and-ale stage (who always can put paying work into the hands of young men), and on fees from classes, journal work, private instruction, and from work in the schools. Any sort of medical practice should be taken, but with caution —too much of it early may prove a good man's ruin. He cannot expect to do more than just eke out a living. He must put his emotions on ice; there must be no "Amaryllis in the shade", and he must beware the tangles of "Neaera's hair." Success during the first ten years means endurance and perseverance; all things come to him who has learned to labour and wait, who bides his time "ohne Hast, aber

ohne Rast", whose talent develops "in der Stille", in the quiet fruitful years of unselfish devoted work. A few words in addition about this dry-bread decade. He should stick closely to the dispensaries. A first-class reputation may be built up in them. Byrom Bramwell's **Atlas of Medicine** largely represents his work while an assistant physician to the Royal Infirmary, Edinburgh. Many of the best-known men in London serve ten, fifteen, or even twenty years in the out-patient department before getting wards. Lauder Brunton only obtaned his full physicianship at St. Bartholomew's after a service of more than twenty years in the out-patient department. During this period let him not lose the substance of ultimate success in grasping at the shadow of present opportunity. Time is now his money, and he must not barter away too much of it in profitless work—profitless so far as his education is concerned, though it may mean ready cash. Too many "quiz" classes or to much journal work has ruined many a promising clinical physician. While the Pythagorean silence of nearly seven years, which the great Louis followed (and broke to burst into a full-blown reputation) cannot be enjoined, the young physician should be careful what and how he writes. Let him take heed to his education, and his reputation will take care of itself, and in a development under the guidance of seniors he will find plenty of material for papers before medical societies and for publication in scientific journals.

I would like to add here a few words on the question of clinical instruction, as with the great prospective increase of it in our schools there will be many chances of employment for young physicians who wish to follow medicine proper as a vocation. To-day this serious problem confronts the professors in many of our schools — how to teach practice medicine to the large classes; how to give them protracted and systematic ward instruction? I know of no teacher in the country who controls enough clinical material for the instruction of classes say of 200 men during the third and fourth years. It seems to me that there are two plans open to the schools: The first is to utilize dispensaries for clinical instruction much more than is at present the rule. For this purpose a teaching-room for a class of twenty five or thirty students immediately adjoining the dispensary is essential. For instruction in physical diagnosis, for the objective teaching of disease, and for the instruction of students in the use of their senses, such an arrangement is invaluable. There are hundreds of dispensaries in which this plan is feasible, and in which the material now is not properly worked up because of the lack of this very stimulus. In the second place, I feel sure that ultimately we shall develop a system of extra-mural teaching similar to that which has been so successful in Edinburgh; and this will give employment to a large number of the younger men. At any large university schools of medicine there might be four or five extra-mural teachers of medicine, selected from men who could show that they were fully qualified to teach and that they had a sufficient number of beds at their command, with proper equipment for clinical work. At Edinburgh there are eight extra-mural teachers of internal medicine whose courses qualify the student to present himself for examination either before the Royal Colleges or the University. If we ever are to give our third and fourth year students protracted and complete courses in physical diagnosis and clinical medicine, extending throughout the session, and not in classes of a brief period of six weeks' duration, I am

confident that the number of men engaged in teaching must be greatly increased.

II

Ten years' hard work tells with colleagues and friends in the profession, and with enlarged clinical facilities the physician enters upon the second, or bread and-butter period. This, to most men, is the great trial, since the risks are greater, and many now drop out of the race, wearied at the length of the way and drift into specialism or general practice. The physician develops more slowly than the surgeon, and success comes later. There are surgeons at forty years in full practice and at the very top of the wave, a time at which the physician is only preparing to reap the harvest of years of patient toil. The surgeon must have hands, and better, young hands. At the end of twenty years, when about forty five, our Lydgate should have a first-class reputation in the profession, and a large circle of friends and students. He will probabily have precious little capital in the bank, but a very large accumulation of interest-bearing funds in his brain-pan. He has gathered a stock of special knowledge which his friends in the profession appreciate, and they begin to seek his counsel in doubtful cases, and gradually learn to lean pon him in times of trial. He may awake some day, perhaps, quite suddenly, to find that twenty years of quiet work, done for the love of it, has a very solid value.

The environment of a large city is not essential to the growth of a good clinical physician. Even in small towns a man can, if he has it in him, become well versed in methods of work, and with the assistance of an occasional visit to some medical centre he can become an expert diagnostician and reach a position of dignity and worth in the community in which he lives. I wish to plead particularly for the wasted opportunities in the smaller hospitals of our large cities, and in those of more moderate size. There are in this State a score or more of hospitals with from thirty to fifty medical beds, offering splendid material for good men on which to build reputations. Take, for example, the town of Thelema, which I know well, to which young Rondibilis, a recent interne at the Hotel Dieu, has just gone. He wrote asking me for a letter of advice, from which I take the liberty of extracting one or two paragraphs:

"Your training warrants a high sim. To those who ask, say that you intend to practice medicine only, and will not take surgical or midwifery cases. X has promised that you may help in the dispensary, and as you can count blood and percuss a chest you will be useful to him in the wards, which, by the way, he now rarely visits. Be careful with the house physicians, and if you teach them anything do it gently, and never crown when you are right. The crow of the young rooster before his spurs are on always jars and antagonizes. Get your own little clinical laboratory in order. Old Dr. Rolando will be sure to visit you, and bear with him as he tells you how he can tell casts from the ascending limb of the loop of Henle. Once he was as you are now, a modern, twenty years ago; but he crawled up the bank, and the stream has left him there, but he does not know it. He means to impress you; be civil and show him the Nissl-stain preparations, and you will have him as a warm friend. His good heart has kept him with a large general practice, and he can put **post-mortems** in your way, and send for you to sit up o'nights with his rich patients. If Y. asks you to

help in the teaching, jump at the chance. The school is not what you might wish, but the men are in earnest, and a clinical microscopy-class or a voluntary ward class, with Y.'s cases, will put you on the first rung of the ladder. Yes, join both the city and the county society, and never miss a meeting. Keep your mouth shut too, for a few years, particularly in discussions.

Let the old men read new books; you read the journals and the old books. Study Laennec this winter; Forbe's **Translation** can be cheaply obtained, but it will help to keep up your French to read it in the original. The old Sydenham Society editions of the Greek writers and of Sydenham are easily got and are really very helpful. As a teacher you can never get **orientiert** without a knowledge of the Fathers, ancient and modern. And do not forget, above all things, the famous advice to Blackmore, to whom when the first began the study of physic, and asked what books he should read, Sydenham replied, **Don Quixote**, meaning thereby, as I take it, that the only book of physic suitable for permanent reading is the book of Nature."

A young fellow with staying powers who avoids entanglements, may look forward in twenty years to a good consultation practice in any town of 40,000 to 50,000 inhabitants. Some such man, perhaps, in a town far distant, taking care of his education, and not of his bank book, may be the Austin Flint of New York in 1930.

"Many are called, but few are chosen," and of the many who start out with high aims, few see the goal. Even when reached the final period of "cakes and ale" has serious drawbacks. There are two groups of consultants, the intra- and the extra-professional; the one gets work through his colleagues, the other, having outgrown the narrow limits of professional reputation, is at the mercy of the **profanum vulgus.** Then for him "farewell the tranquil mind, farewell content". His life becomes an incessant struggle, and between the attempt to carry on an exhausting and irksome practice, and to keep abreast with young fellows still in the bread-and-butter stage, the consultant at this period is worthy of our sincerest sympathy.

One thing may save him. It was the wish of Walter Savage Landor always to walk with Epicurus on the right hand and Epictetus on the left, and I would urge the clinical physician, as he travels farther from the East, to look well to his companions—to see that they are not of his own age and generation. He must walk with the "boys", else he is lost, irrevocably lost; not all at once, but by easy grades, and every one perceives his ruin before he, "good, easy man", is aware of it. I would not have him a basil plant, to feed on the brains of the bright young fellows who follow the great wheel uphill, but to keep his mind receptive, plastic, and impressionable he must travel with the men who are doing the work of the world, the men between the ages of twenty-five and forty.

In the life of every successful physician there comes the temptation to toy with the Delilah of the press—daily and otherwise. There are times when she may be courted with satisfaction, but beware! sooner or later she is sure to play the harlot, and has left many a man shorn of his strength, viz., the confidence of his professional brethren. Not altogether with justice have some notable members of our profession laboured under the accusation of pandering too much to the public. When a man reaches the climacteric, and has long passed beyond the professional stage

of his reputation, we who are still "in the ring" must exercise a good deal of charity, and discount large the **on dits** which indiscreet friends circulate. It cannot be denied that in dealing with the public just a little touch of humbug is immensely effective, but it is not necessary. In a large city there were three eminent consultants of world-wide reputation; one was said to be a good physician but no humbug, the second was no physician but a great humbug, the third was a great physician and a great humbug. The first achieved the greatest success, professional and social, possibly not financial.

While living laborious days, happy in his work, happy in the growing recognition which he is receiving from his young colleagues, no shadow of doubt haunts the mind of the young physician, other than the fear of failure; but I warn him to cherish the days of his freedom, the days when he can follow his bent, untrammeled, undisturbed, and not as yet in the coils of the octopus. In a play of Oscar Wilde's one of the characters remarks, "there are only two great tragedies in life, not getting what you want—and getting it!" and I have known consultants whose treadmill life illustrated the bitterness of this mot, and whose great success at sixty did not bring the comfort they had anticipated at forty. The mournful echo of the words of the preacher rings in their ears, words which I not long ago heard quoted with deep feeling by a distinguished physician, "Better is an handful with quietness, than both the hands full with travail and vexation of spirits."

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NOTAS EDITORIALES

Hemos de confesar que nos sentimos profundamente halagados ante el sincero encomio y la sincera crítica, que han logrado despertar nuestros editoriales entre la clase médica puertorriqueña. Un grupo numeroso de médicos de la isla y algunos de San Juan, por medio de mensajes que hemos sabido agradecer, han expresado con cálidas y generosas frases, su respaldo para las ideas emitidas en la carta al Dr. Susoni, y en las notas alrededor de la Bibliopelícula y sus orientaciones culturales.

La carta al Dr. Susoni, donde enjuiciábamos la incomprensión de los legisladores, y donde aseverábamos que esa incomprensión había sido basada sobre estadísticas divorciadas de la realidad económica del país, fué **"sumamente jabonosa"** para algunos, mientras para otros fué **"pregón del vetusto chauvinismo que domina en nuestra clase".**

Las notas alrededor de la Bibliopelícula de la Biblioteca de la Escuela de Medicina Tropical, donde entusiastas exaltábamos sus posibilidades culturales, y donde entristecidos señalábamos el espectáculo deprimente de salones de lectura que nadie visitaba, también fueron objeto de los más enconados comentarios, enfocados todos sin embargo, en la crítica de los objetivos de enseñanza de la escuela y no en el objetivo editorial.

Es conveniente recordar que en esas mismas notas editoriales que por haber sido objeto de controversia nos vemos obligados a comentar, señalábamos la carencia de bibliotecas de consulta, tanto en los Hospitales del Distrito como en el Hospital Municipal de San Juan; y nadie, hasta la fecha, ha tenido la inquietud de demostrar el error de nuestras apreciaciones.

Cabe pensar si esa inmotivada carencia de libros de consulta que padecen los jóvenes médicos, precisamente en aquellas instituciones donde la inmensa mayoría hace su internado, no explica de una manera satisfactoria el espectáculo de frustrada soledad que casi reina en la Biblioteca de la Escuela de Medicina Tropical, y que impera con absoluto dominio en la Biblioteca de la Asociación Médica de Puerto Rico.

Yerran los que creen que la clase médica puertorriqueña está haciendo el más mínimo esfuerzo por desacreditar la conjura organizada que de una manera ostensible diariamente debilita los cimientos custodios de nuestra asociación y de nuestra clase. Yerran, desgraciadamente también, los que se acojen al piadoso pensar, que es absolutamente gratuita e inmotivada esta agresiva campaña, y han adoptado el hábito de mirar con desdén sus posibles y mediatas consecuencias. Andan fuera de camino los que toman iglesia en el cómodo silencio y solo infraccionan sus métodos de vida, con el latiguillo del tenue comentario que se pierde en el vacío.

Esa crítica y ese comentario; la del que encomia y la del que disiente, no tiene justificación alguna en el momento actual. Nosotros como hombres prácticos, debemos con urgencia, olvidando la vieja canción de las prerrogativas y de los legados de nuestros antecesores, comenzar diligentemente el arreglo de nuestra casa. Hemos dejado que el redoble del tambor no se perciba en nuestras filas, y hemos perdido el ritmo de la marcha.

La crítica y el comentario que ha de propender a poner nuestra casa en orden, ha de ser la amplia y serena discusión. El cálido encomio rara vez inspirador, y la crítica severa y enconada en muy pocas ocasiones contructiva, no podrán encararse con la magnitud del problema.

REVISTA DE REVISTAS

La diferenciación del carcinoma bronquiogénico y la tuberculosis pulmonar, H. R. Pillsbury y J. D. Wassersug, New England J. Med., March 8, 1945, 232: 276.

El diagnóstico diferencial entre la tuberculosis pulmonar y el cáncer bronquiogénico, se presta aún a innumerables confusiones, pues los signos y síntomas son comunes a ambas enfermedades, informan los observadores Bostonienses. Los hallazgos radiológicos, tales como la infiltración, la atelectasia y aún la caverna, también según Pillsbury y Wassersug, ocurren con más o menos idéntica frecuencia, tanto en la tuberculosis como en el cáncer del pulmón.

En el Hospital para tuberculosos del Condado de Norfolk 12 casos de carcinoma fueron referidos, en el período de 10 años, como casos de tuberculosis pulmonar, y el diagnóstico fué finalmente hecho mediante la exploración broncoscópica. Los autores no informan los hallazgos radiológicos que dieron lugar al error de diagnóstico en los 12 casos ya mencionados, y no aducen criterio clínico ni radiológico para un diagnóstico diferencial. El criterio sustentado, parece descansar, en que si "la broncoscopía no es concluyente, otras medidas de diagnóstico están inmediatamente indicadas."

Efisema espontáneo del mediastino con neumotórax, simulando lesión orgánica del corazón, H. Miller, Am. J. Med. Sc., Febrero 1945, 209: 211.

El autor ha tenido la excepcional oportunidad de observar 8 casos de enfisema del mediastino, en el transcurso de los últimos tres años. En seis casos, la exploración radiológica identificó un neumotórax del lado izquierdo.

La evidencia clínica consiste principalmente en la brusca aparición de un dolor precordial o subesternal, cuya severidad depende del grado de distensión de los tejidos del mediastino. El dolor puede reflejarse en la espalda, hombro o en el lado izquierdo, y puede persistir por horas o por días. El signo patognomónico es un sonido peculiar audible sobre el precordio y sincrónico con los latidos del corazón. El sonido o ruido es descrito por el autor como un crujido.

Se comenta el trabajo experimental de Macklin que explicó racionalmente como la burbuja de aire abriéndose paso por entre los tejidos perivasculares, da origen a la vesícula subpleural, y finalmente al neumotórax.

Las observaciones de Hamman, el primer observador de este interesante síndrome, merecen por parte del autor valiosos comentarios.

Tratamiento y pronóstico del megacolon, Griwson, K. S. V. y Vandergriff, S., Am. Jour. of Dis. of Child., 1945.

Un grupo de 24 pacientes fueron observados y tratados en la Clínica Duke por los autores. 21 fueron tratados médicamente por medio de dieta, laxantes y enemas; 3 fueron tratados de urgencia por obstrucción intestinal; 6 quedaron bien; 7 no sufrieron modificación alguna en su sintomatología; 5 fallecieron y 3 viven sin síntomas, después de la resección parcial del colon con íleosigmoidostomía.

Los autores clasifican el megacolon en tres grupos, a saber: 1. Dilatación total, donde el tratamiento médico parece ser indicado, mientras pueda mantenerse un estado de nutrición adecuado y evitarse la distensión abdominal. 2. Dilatación de

los segmentos proxi con recto normal donde la resección es de urgencia. Si no es posible se practicará la colostomía. 3. Dilatación del descendente y sigma, donde el tratamiento médico parece estar justificado.

Los autores analizan los casos de la literatura del megacolon permanente, llegando a la conclusión que el tratamiento médico rinde pocos beneficios y la resección segmetaria además de ser peligrosa presenta el inconveniente de las frecuentes recurrencias. Por tales observaciones, ellos creen que la simpatectomía, en colaboración con el tratamiento médico, puede ayudar efectivamente en el tratamiento.

El factor infección en las formaciones quísticas broncopulmonares, R. Vaccareza y J. Peroncini, An. Cadet. de pat. y clin. tuberc., Diciembre 1943, 5: 199.

Los autores informan con lujo de detalles, 10 casos de quistes pulmonares, en 2 de los cuales la presencia de tuberculosis fué identificada. La prevención de las infecciones de estos quistes, y la obstrucción bronquial por medio de sulfoterapia y del drenaje postural, es ampliamente discutida.

Ellos clasifican estas malforaciones quísticas, en seis grupos: 1. Agenesia pulmonar; 2. Bronquiectasia hipoplástica; 3. Bronquiectasia diplástica; 4. Quiste gaseoso; 5. Quistes múltiples y; 6. Enfisema vesiculado. Resalta a primera vista que estos observadores difieren completamente de las clasificaciones anatómicas en boga, especialmente la de Auspach y Wolman, y también de aquellas que consideran la base etiológica, como Daniel y Jezsovics.

Según estos autores estas malformaciones quísticas pueden existir sin aparentes características clínicas ni radiológicas, hasta tanto el factor infección hace posible que la insuflación de aire y acúmulo de secreciones, las haga visibles y las convierta en productores de síntomas.

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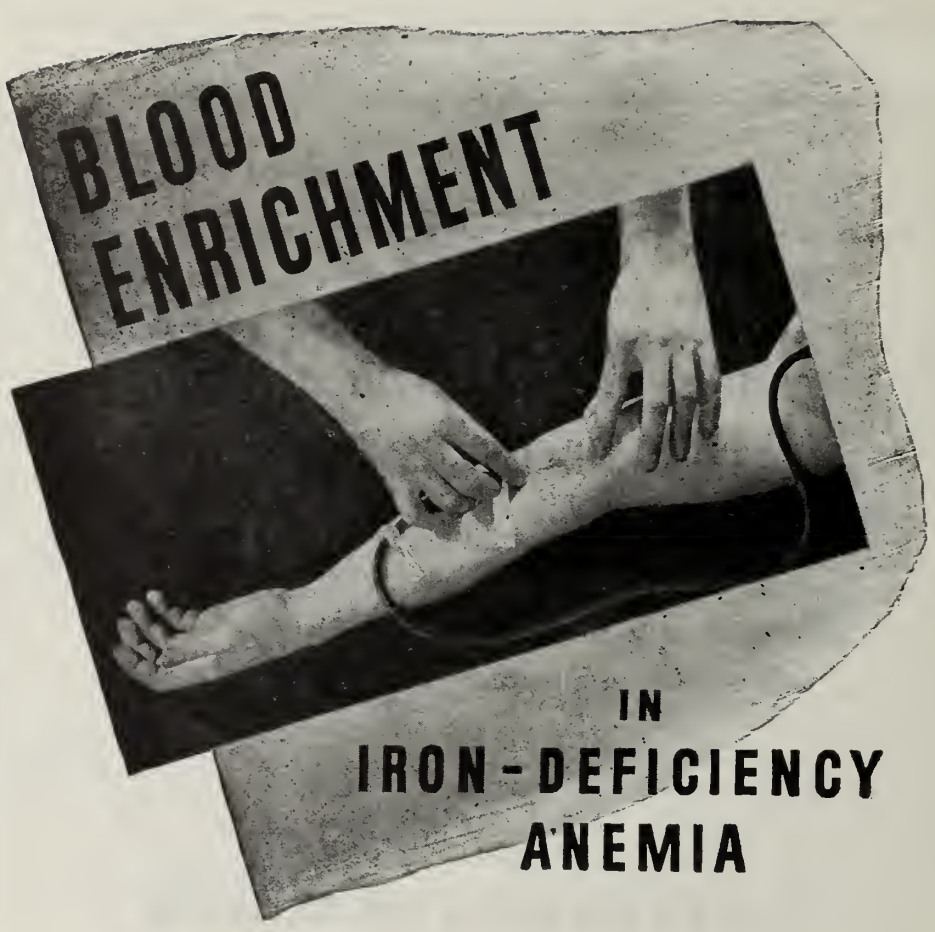

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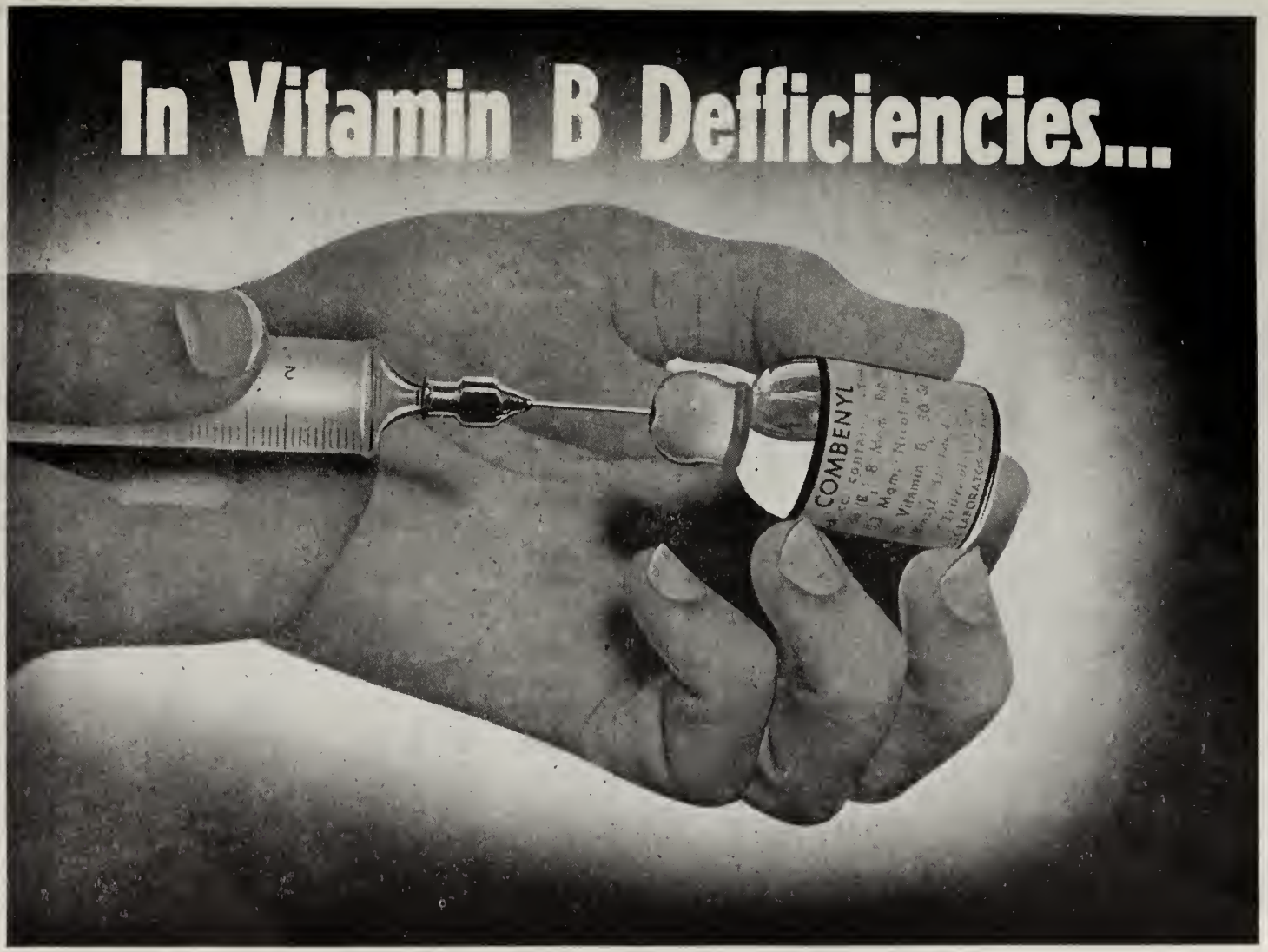

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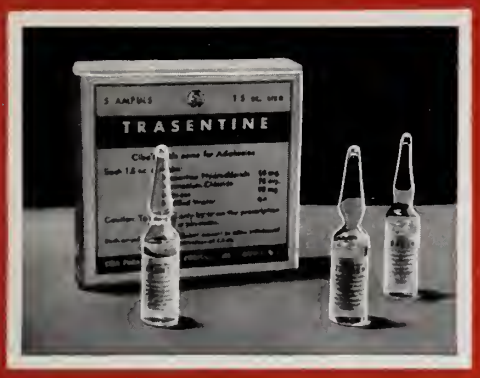

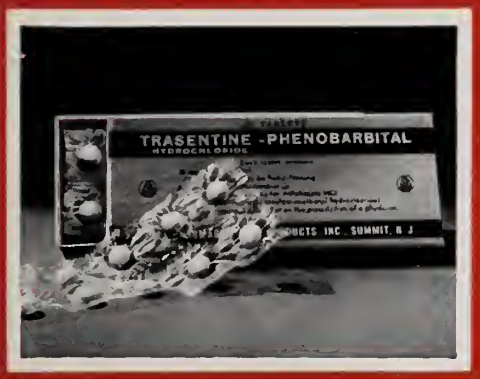

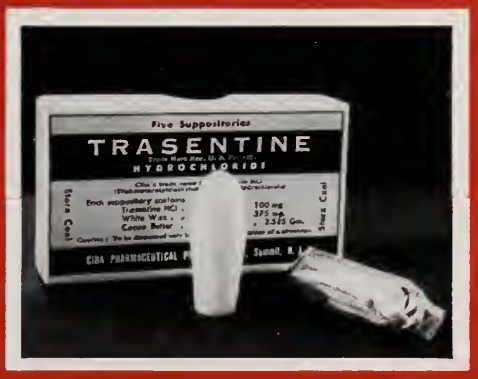

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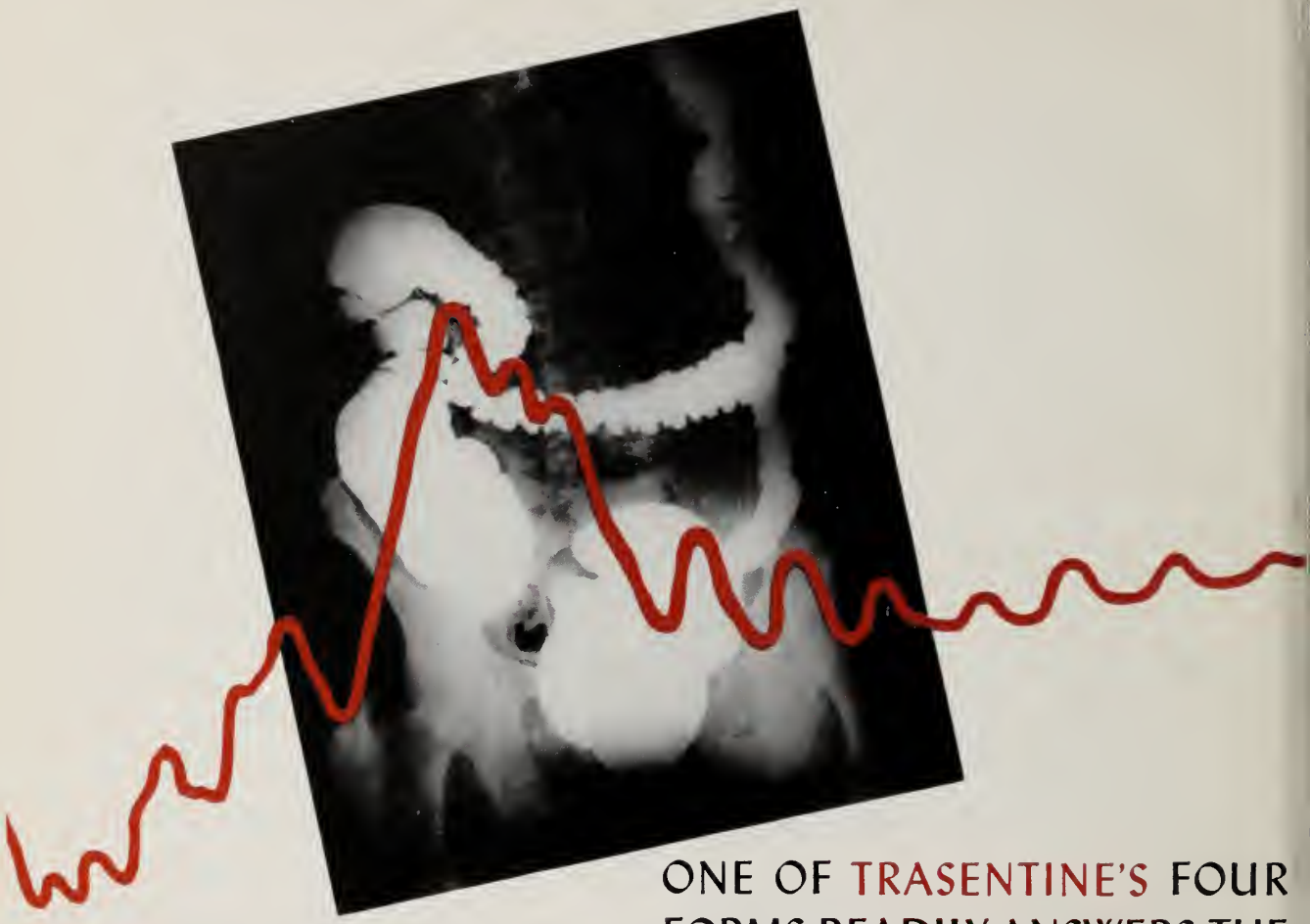

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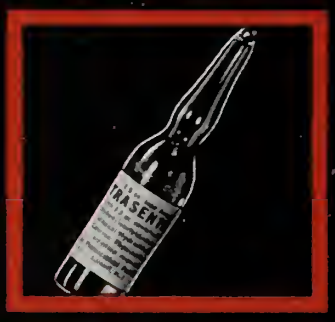

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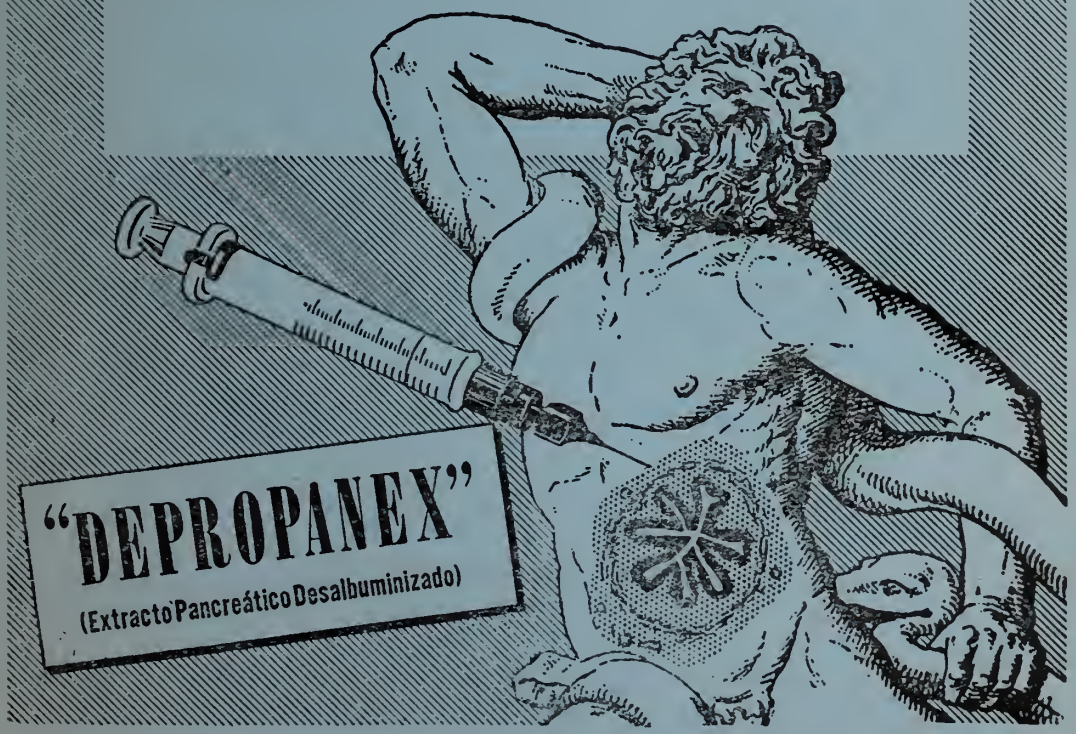

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